ENVISION
MEDICAL IMAGING
A member of Qscan Group

PSMA Patient Information, Consent and Checklist

PSMA PET-CT INFORMATION and PREPARATION

IMPORTANT: PLEASE READ CAREFULLY AND FOLLOW INSTRUCTIONS CLOSELY

PET (Positron Emission Tomography) uses small amounts of short-lived radioactivity to detect abnormalities within cells in your body.

PSMA (Prostate Specific Membrane Antigen) is a peptide that is expressed on the surface of certain cells. This peptide is linked to a radioactive isotope, and will bind to any cells in the body which express PSMA on their surface.

A PSMA PET-CT scan is most commonly used to stage prostate cancer in patients who have had a positive biopsy, or who have had their prostate removed but now have increasing PSA levels. This scan may also be used to stage or plan therapy for other cancers.

During the test the radioactive peptide will be injected into a vein in your arm. It has no side effects, and you will experience no unusual sensations.

Following the injection, there is a period of rest in a quiet room for 1 hour while the injection is absorbed.

After this time the PET images will be taken, and CT scans if required, taking 25-35 mins. You will need to lie flat and remain still for the scans.

You are able to leave shortly after the scan is completed. You will remain radioactive for a short period of time, and contact with small children and pregnant women should be limited for 4 hours from the time of injection.

The total time taken for this procedure is 2-3 hours. The report will be sent electronically to your referring doctor when complete.

For additional information about PET-CT please visit our website www.envisionmi.com.au

PREPARATION

1. Please fast for 2 hours prior to your appointment. You may take medications as required.
2. Drink 4 glasses of water during the hour prior to your appointment (1 glass every 15 minutes). You may go to the toilet as necessary.
3. Wear warm, metal-free clothing and remove jewellery.

Have you had any scans relevant to your current condition? i.e. PET/ MRI/CT/Bone scan			YES	NO
If YES, where? *Envision* *PRC* *SKG* *SCGH/FSH* *Other* _____				
When were your diagnosed with your condition?				
Have you had any treatment for cancer?			YES	NO
Surgery?	YES	NO	*When, and what body part?*	
Radiation Therapy?	YES	NO	*When, and what body part?*	
Hormone Therapy?	YES	NO	*When?*	
What is your current PSA level (if known)?				

I have read this form, understand the purpose of the tests, and consent to the test being performed.

Patient Name		
Patient Signature *(or signature of legal guardian)*		Date
Signature of MIT/Radiologist	Signature of MIA/Nurse	

OFFICE USE ONLY

PT ID: ☐ NAME ☐ DOB ☐ ADDRESS **PROCEDURE:** ☐ EXAM ☐ SIDE ☐ CONSENT

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INFORMATION & CONSENT FORM

CONTRAST MEDIUM - INTRAVENOUS

Introduction
The scan your doctor has asked us to perform may require the injection of contrast medium. This is a medical dye used to allow or improve detection of abnormalities in the body. The intravenous contrast is iodine based.

If you have any allergies to X-ray dye or iodine, please inform the staff member prior to commencing the scan.

Please ask questions about anything on this form that you do not understand.

Risks and side effects
As with most drugs, side effects and adverse reactions are possible. These may occur during or after the procedure.

Side effects associated with the procedure may include a feeling of warmth or a metallic taste in the mouth. Occasionally side effects such as nausea or rash *(hives)* may occur. More severe allergic reactions may result in shortness of breath and facial swelling. It is extremely rare for reactions to be life threatening.

I have read the information provided regarding my procedure. I understand the information and have had the opportunity to ask questions about what is going to happen, the reasons for the procedure being performed, and the associated risks. I agree to have the procedure performed.

To further reduce the risk of an adverse reaction it is important that you answer the following questions. Please circle your response and answer all questions this page.

Have you previously had an injection of X-ray contrast?	YES	NO
If YES, did you have an adverse reaction to the X-ray contrast?	YES	NO
Do you have any known **Allergies?** e.g. Iodine	YES	NO
If YES, please list		
Do you take **diabetic tablets?**	YES	NO
If YES, are you on Diabex, Diaformin, Glucohexal, Glucomet, Glucophage, Glucovance, Novomet, Avandamet		
Do you have poor kidney function?	YES	NO
If YES, date: *eGFR* *Creatinine level*		
Do you have **Asthma?**	YES	NO
Are you on blood thinning medication? e.g. Warfarin, Plavix, Aspirin	YES	NO
Have you used **Viagra, Cialis,** or a **similar** drug in the last 48 hours?	YES	NO
Have you had any **heart surgery?** (i.e. Stents, Bypass) Give details:	YES	NO
Do you take any blood pressure or heart medication?	YES	NO
If YES, please list		
Weight (kg) Height (cm)		
Is there any chance you may be pregnant?	YES NO	N/A

Patient Name		
Patient Signature *(or signature of legal guardian)*		Date
Signature of MIT / Radiologist		

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NO CO2