



HOSPITAL _____

Nuclear Medicine Operational Unit
 Fax: _____ ; Phone: _____ ; Email: _____ @ _____

Appointment sheet for SPECT CON I 123 FP-CIT/I 123 IBZM

| | | |
|----------------|-----------------------------|---------|
| Exam code No.: | Compilation date: / / | Rev. 00 |
|----------------|-----------------------------|---------|

| | |
|---------------------|-------------------------------|
| LAST NAME: | FIRST NAME: |
| PLACE OF BIRTH: | DATE OF BIRTH: |
| CITY OF RESIDENCE: | STREET: |
| PHONE: | |
| HEALTHCARE/ID CARD: | ASL (Local Health Authority): |

| | |
|--|---|
| Patient characteristics on day of exam | <input type="radio"/> External <input type="radio"/> Internal <input type="radio"/> D.H. <input type="radio"/> D.P. |
| Weight-Height | kg _____ cm _____ |
| Right/left handed | <input type="radio"/> Right <input type="radio"/> Left |
| Claustrophobic | <input type="radio"/> Yes <input type="radio"/> No |
| Cooperative patient | <input type="radio"/> Yes <input type="radio"/> No Sedation requested <input type="radio"/> Yes <input type="radio"/> No |
| Pregnancy | <input type="radio"/> Yes <input type="radio"/> No - pre-menopausal women should avoid taking an exam during menstruation and ovulation periods |

| | |
|---|--|
| Diagnostic hypothesis: | |
| Clinical request: | |
| Parkinson <input type="radio"/> MSA <input type="radio"/> PSP <input type="radio"/> Essential tremor <input type="radio"/> Iatrogenic Parkinsonism <input type="radio"/> CBD <input type="radio"/> DLB <input type="radio"/> Vascular Parkinsonism <input type="radio"/> Other Parkinsonisms <input type="radio"/> Other <input type="radio"/> | |

| General anamnestic notes: | | | | | | | | | | | | | | | | | |
|---|---|------|------|------|----|--|--|--|--|--|--|--|--|--|--|--|--|
| Current clinical environment: | | | | | | | | | | | | | | | | | |
| Start of illness | | | | | | | | | | | | | | | | | |
| Anti-Parkinson medication | <table border="1"> <thead> <tr> <th>Name</th> <th>Dose</th> <th>from</th> <th>to</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table> | Name | Dose | from | to | | | | | | | | | | | | |
| Name | Dose | from | to | | | | | | | | | | | | | | |
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| Therapeutic complications and date of onset: | | | | | | | | | | | | | | | | | |

| | | | |
|--------------------|------------|---|-----------|
| Clinical tests | MMSE. /30. | H&Y I. <input type="radio"/> II. <input type="radio"/> III. <input type="radio"/> IV. <input type="radio"/> | UPDRSIII: |
| Instrumental exams | CT/MRI | | |
| | SPECT/PET | | |

Date: _____ Prescribing physician _____ U.O. /Other center: _____
 FAX: _____ Phone: _____
 Email: _____ @ _____

Date: _____ Nuclear physician _____