Rock Road
Blackrock
Co Dublin
Ireland

Tel: 00-353-1-206 4373
Fax: Nuclear Medicine: 00-353-1-206 4290
Fax: 00-353-1-283 2297 (PET/CT)

BLACKROCK CLINIC

Nuclear Medicine/PET Scanning Centre

To: **Fax:**

Date: **Pages: 2**

ST. PAUL'S GARDA MEDICAL AID SOCIETY - PRE-AUTHORIZATION FORM

This form needs to be completed by the referring consultant and returned by fax to Nuclear Medicine, Blackrock Clinic – (**Fax: 01 2832297**).

N.B: Please ensure that you attach relevant CT/MRI/Histology reports as GMA will not review request without relevant clinical data. We also require that you include a letter of request to us, separate to the GMA form, to perform the PET/CT scan. Please indicate if patient has undergone any chemotherapy/radiotherapy and if patient is a diabetic as these can determine when we can do the scan.

We need to have prior approval from GMA before going ahead with the PET scan so it is imperative that you return this form to me **ASAP.**

Please ensure you send us the following information:

1.	**Patient's name, date of birth, address, contact numbers**	
2.	**CT, Histology and relevant reports**	
3.	**CT films or CD required (not applicable to SVUH/SVPH)**	
4.	**Please furnish us with your contact details – telephone, bleep, mobile**	
5.	**Fax number for PET/CT results**	

Plaza 255
Blanchardstown Corporate Park 2
Ballycoolin Road
Dublin 15

Telephone: 01 899 1601
Fax: 01 899 1707
E-mail: customerservice@medicalaid.ie
Website: www.medicalaid.ie

St. Pauls Garda Medical Aid Society

PRE-AUTHORISATION FORM - PET SCAN.

To: Office Manager
Garda Medical Aid Society.
Plaza 255
Blanchardstown Corp. Pk. 2
Dublin 15

From _____
_____
_____
_____
Reply Fax No. or email address _____

Patient Name _____ Membership No. _____

Proposed Date For scan _____

Diagnosed Condition Requiring PET scan _____

Date of onset of condition and Previous History and Treatment to date _____

_____

_____

Previous Investigations/Scans and results _____

_____

Clinical reasons why a PET scan is indicated in preference to other diagnostic techniques _____

_____

_____

The above information is required to determine if pre-approval for payment will be given.
Note; GMA covers the cost of one PET scan per diagnosis.

I certify that the proposed PET scan is an integral and clinically necessary part of my recommended course of treatment for this patient.

Consultants Signature _____
Block Capital ( )

Approved by _____ Office Manager.

Fax this form to 01 8991707 or email to customerservice@medicalaid.ie