In-111 PENTETREOTIDE (OCTREOSCAN®) IMAGING
RECORD OF TELEPHONE SCHEDULING

Patient: ____________________________ Sex: _____ Birthdate: ____________

Telephone: ____________________________

Referring Physician: ____________________________ Telephone: ____________________________

Pertinent History and ALL Current Medications:
(Octreotide (Sandostatin®) should be withheld for 48-72 hours before imaging, if possible.)

Results of Other Imaging Studies:

Laboratory Tests Indicative of Presence of a Neuroendocrine Tumor:

<table>
<thead>
<tr>
<th>Date</th>
<th>Test</th>
<th>Result</th>
<th>Normal Range</th>
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CHECKLIST (All must be verified before study can proceed)

1. Referring physician understands that In-111 Pentetreotide (Octreoscan®) is expensive ($1,400 drug charge) and that patient will be charged for the radiopharmaceutical if a scheduled study is canceled on the day it is to be performed? Referring physician also understands that patient must be able to return for imaging at 4 and 24 hours (and possibly 48 hours)?

YES_______

OVER

Check for current form at:  Revised 16-Feb-04
http://gamma.wustl.edu/division/clinical-information.html
2. Patient does not have known hypersensitivity to Octreotide (Sandostatin®)?

CONFIRMED

3. Patient is male____; postmenopausal female____;
or S/P either tubal ligation or hysterectomy______?

If none of the above, indicate below how pregnancy has been or will be excluded.

OR

Pentetreotide scintigraphy needs to be done irrespective of pregnancy status______

4. Patient is not breastfeeding.

CONFIRMED_____

(Note that In-111 Pentetreotide scintigraphy can be performed in pediatric, pregnant, or
nursing patients if the benefits are thought to outweigh the risks.)

5. Study will require SPECT (6 mCi dose) rather than planar imaging only (3 mCi dose)?

SPECT______vs. Planar Only______

6. Date for study confirmed with Radiopharmacy_____

7. Dates test to be performed: Injection________________________Imaging____________________

8. Front Desk Notified that Patient on Schedule? _______________________________________
[Do not schedule > 2 patients/day for imaging without approval of charge technologist.]

_____________ M.D. _______________ M.D.
Date Scheduling Physician Signature Staff Physician Co-signature