NATIONAL HOSPITAL INSURANCE FUND

P.O. BOX 30443 - 00100, NAIROBI

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REFFERAL FORM FOR PET CT-SCAN

PART A: PATIENT PARTICULARS (To be completed by the Principal member)

Name of the Principal Member:		**NHIF No:**	**ID No/Passport No:**
County of origin:		**Gender: (F/M)**	**Age:**
Email address:			**Tel. No:**
Name of the Patient:		**Patient ID NO:**	**Relationship of the Principal Member: (Self/Spouse/Dependant)**
Employer (where applicable)			
Co-Insurance? Yes ☐ No ☐ **If yes, please state Insurer/Sponsor** ___________			
I certify that the above information is correct and give specific consent for selected oncology service(s) to be done. I undertake to pay any monies not catered for by my medical scheme, subject to scheme rules and necessity of the prescribed services. I understand that it is an offence to knowingly make any false statement for purposes of obtaining any benefit under NHIF Act. **Signature:** ______________________ **Date:** ____________________________			

Part B: Details of the illness and planned management (To be filled by referring oncologist /radio-oncologist)

Diagnosis:	**Staging:**
Metastases: Lung ☐ Brain ☐ Bone ☐ Liver☐ Other ☐	
How long have you treated/managed the patient?	
Reason for PET scan Diagnostic ☐ Assessment after treatment ☐ Recurrence ☐ Other ☐ Specify ______________________	

- **If prior PET scan done, please indicate date and attach report.**

- **Prior treatment plans accessed** (Indicate all treatment specifying if surgery, chemotherapy, radiotherapy, or any other treatment given)

UNDERTAKING BY ONCOLOGIST / RADIO-ONCOLOGIST

I certify that the above request(s) are medically necessary in the care of this patient. All the above particulars furnished are true/correct. The Member has signed the undertaking before me.

Name: …………………………………………………………… **KMDPB Reg. No: ………………………**

Signature: ……………………………………………… **Date: ……………………………**

Hospital Stamp

PART C: TO BE FILLED BY THE OFFICE OF THE DIRECTOR GENERAL

Approval is hereby given for…………………………………………………………who has been referred for a PET-CT Scan by Dr./Prof: ………………………………………………………………………

Signature: ………………………… **Date…………………**

Name: ………………………………………………………………………………

Director General for Health.

Official Stamp of the Ministry of Health