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| *Nacionālā veselības dienesta* *2020.gada \_\_\_.aprīļa rīkojuma Nr.\_\_\_\_\_\_\_\_\_\_\_2.pielikums**Līguma par sekundārās ambulatorās veselībasaprūpes pakalpojumu sniegšanu un apmaksu7.1.20.punkts* |
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| **Nosūtījums pozitronu emisijas datortomogrāfijas ambulatoram izmeklējumam** |
| 2. Maksātājs NVD[ ]  Cits [ ]  |
| 3. Pacienta vārds, uzvārds\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4. Personas kods  | [ ] [ ] [ ] [ ] [ ] [ ] -[ ] [ ] [ ] [ ] [ ]  |
| 5. Deklarētā dzīvesvieta \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 6. Pacienta kontaktinformācija \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  |
| 7.Diagnoze apstiprināta (dd.mm.gggg.)(Norāda, ja diagnoze ir apstiprināta morfoloģiski) | [ ] [ ] .[ ] [ ] .[ ] [ ] [ ] [ ] . |
| 8. Pilna diagnoze (SSK-10 diagnozes kods ar vismaz četrām zīmēm):8.1. pamatslimība 8.2. sarežģījumi, komplikācijas | [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]  |
| 9.TNM klasifikācija (Limfoīdo audu audzēju gadījumos sadaļu neaizpilda) Ja dažādu iemeslu dēļ tas nav iespējams, tad jāsniedz paskaidrojums (piemēram, nav veikta operācija) |  **T**[ ]  **N**[ ]  **M**[ ]  **G**[ ]  **pT**[ ]   |
| 10. Slimības stadija (Limfoīdo audu audzēju gadījumos sadaļu neaizpilda)Norāda slimības stadiju *(O, Ois, OA, I, IA, IA1, IA2, IB, IB1, IB2, IC, II, IIA, IIB, IIC, III, IIIA, IIIB, IIIC, IV, IVA, IVB, IVC, neprecizēta – X)* | [ ] [ ] [ ] [ ]  |
| 11. Apraksts: |  |
| 11.1.Nosūtījuma mērķis:  |  |
| Limfomas izplatības noteikšanai pēc ķīmijterapijas, tālākās terapijas izvērtēšanai [ ] Remisijas apstiprināšanai pēc terapijas saņemšanas [ ] Limfomas recidīva apstirpināšana [ ] Mielomas ekstramedullāra diseminācija [ ] Sēklinieku audzēja, neseminoma, kontrole pirms autologas cilmes šūnu transplantācijas [ ] Sēklinieku audzēja, neseminoma, kontrole pēc autologas cilmes šūnu transplantācijas [ ] Kastelmana slimība [ ] Cits: [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| 12. Īsa anamnēze par pacientu, kas nepieciešama PET/CT izmeklējuma veikšanai: Klaustrofobija [ ]  Jā [ ]  Nē Kustību traucējumi [ ]  Jā [ ]  Nē CT kontrastvielas alerģija [ ]  Jā [ ]  Nē Spēj nogulēt uz muguras nekustīgi 30-60 minūtes [ ]  Jā [ ]  Nē Operācija pēdējo 6.ned. laikā [ ]  Jā [ ]  Nē \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (kas un kādā veidā bijusi operācija?) Ķīmijterapija pēdējo 6.ned. laikā [ ]  Jā [ ]  Nē \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (kad saņemta un pabeigta?) Staru terapija pēdējo 6.ned. laikā [ ]  Jā [ ]  Nē \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (kad saņemta un pabeigta?) CT pēdējo 6.ned. laikā [ ]  Jā [ ]  Nē \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (kad, kur?) PET/CT pēdējo 2 gadu laikā [ ]  Jā [ ]  Nē \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (kad, kur?) Cukura diabēts [ ]  Jā [ ]  Nē \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (glikozes līmenis diabētiķim, datums) Vairogdziedzera hiperfunkcija [ ]  Jā [ ]  Nē \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (aktuālais TSH līmenis, datums) GFĀ noteikšana [ ]  Jā [ ]  Nē \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (aktuālais kreatinīna un GFĀ līmenis, datums) Pacienta ķermeņa svars un garums \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (aktuālais ķermeņa svars (kg), garums (cm)) Koloniju stimulējoša faktora saņemšana\* [ ]  Jā [ ]  Nē \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (kad saņemta? (datums))  Jā Nē Jā NēTuberkuloze [ ]  [ ]  Sarkoidoze [ ]  [ ]  Sinusīts [ ]  [ ]  HIV/AIDS [ ]  [ ]  Elpceļu iekaisuma slimības [ ]  [ ]  Zarnu iekaisuma slimības [ ]  [ ]  Reimatoīdais artrīts [ ]  [ ]  Vīrusu hepatīts (VHB, VHC) [ ]  [ ]  Paaugstināta ķermeņa temperatūra pēdējās nedēļas laikā [ ]  [ ]  Sievietēm reproduktīvā vecumā: Jā Nē Jā NēGrūtniecība [ ]  [ ]  Cikls regulārs [ ]  [ ]  Pēdējās menses \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bērna zīdīšana [ ]  [ ]    |
| 13. Citi komentāri: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_14. Ārstu konsīlija datums (konsīlija datums, konsīlija vadītāja vārds, uzvārds, identifikators, informācija par ārstiem, kas piedalījās konsīlijā (vārds, uzvārds, identifikators, specialitāte)):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_15. Slimības gaita un ārstēšanas apraksts\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 16. Ārstniecības iestāde, kas aizpildījusi nosūtījumu (kods, nosaukums) |
| 17. Datums (dd.mm.gggg.) |  [ ] [ ] .[ ] [ ] .[ ] [ ] [ ] [ ] . |

\*obligāti aizpildāmie lauki ļaundabīgo audzēju gadījumos