NUCLEAR MEDICINE PET/CT REQUEST FORM

268 Grosvenor Street
5th Floor, Room B5-204
Ph. 519-646-6000 Ext. 64137
Fax. 519-646-6135

Referred by: (PLEASE PRINT)

Physician's Name: ______________________________________

Phone No. :____

Fax No.:____

Patient Name:____

Address:____

City: _________________**Postal Code**:_____________ **Phone No.**: _________________ **DOB (yy/mm/dd)**: ____________________

OHIP No.: __ __ __ __ __ __ __ __ __ __ (____) *Version code* **Height**: _________**cm** **Weight**____________**kg**

Insured Services:

- ☐ Post Therapy Lymphoma
- ☐ Solitary Pulmonary Nodule (SPN)
- ☐ Non-small Cell Lung Cancer
- ☐ Limited Disease Small Cell Lung Cancer
- ☐ Thyroid Cancer
- ☐ Colorectal Cancer
- ☐ Germ Cell Tumours
- ☐ Esophageal Cancer
- ☐ Metastatic Squamous Cell Carcinoma – Evaluation of Neck Nodes
- ☐ Liver Metastasis from Colorectal Cancer

PET Registry:

- ☐ Paediatric
- ☐ Pancreatic Cancer
- ☐ Melanoma
- ☐ Lymphoma (please attach registry forms)
- ☐ Staging of Hodgkin's or non-Hodgkins Lymphoma
- ☐ Staging of Nodal Follicular Lymphoma or other Indolent non-Hodgkin's Lymphomas

*For patients who may benefit from PET, but who do not meet the eligibility criteria, please visit the PET Scans Ontario (www.petscansontario.ca) to download forms for the **PET Access Program** and to obtain information regarding currently available **clinical trials**.*

Additional Clinical Information:
____

____

Is the patient diabetic? □ Yes □ No – If yes, please list medications used to control patient's diabetes ______________________________

____

Has there been a biopsy? □ Yes □ No – If yes, please give date and site of biopsy on body ___________________________________

____

Has there been surgery? □ Yes □ No – If yes, please give date, reason and site on body of surgery ______________________________

____

Radiation Therapy: Please list all dates.

Past: __________________________ Present: ____________________ Future: _______________________

Chemotherapy: Please list all dates.

Past: __________________________ Present:_____________________ Future:________________________

Does the patient have a history of the following conditions? Please check all that apply.

☐ Tumor	☐ Smoking	☐ Asbestos Exposure	☐ Stroke	☐ Coronary Artery Disease
☐ Seizures	☐ Thyroid Disorder	☐ Liver Disease (Cirrhosis)	☐ Memory Problems	☐ Claustrophobia

If yes to any of the above, please provide an explanation: ____

____

Please list all current medications: ____

____

To be completed by Nuclear Medicine

PET Scan Appointment:

Date: ______________________

Time: ______________________

Please attach the most recent consult note if from outside of London, Ontario

REF. PHYSICIAN SIGNATURE: ______________________________ **DATE**:____________________

Revised: April 27, 2016