Thunder Bay Regional Health Sciences Centre

Nuclear Medicine & Molecular Imaging

# PET/CT REQUEST

**Guidelines**:

1. Physician to sign requisition. Incomplete requisitions will be returned.
2. Fax requisition to PET/CT booking clerk at **807-684-5907**.
3. If there is relevant prior imaging from **outside facilities** (e.g. Kenora, Winnipeg) please provide reports and CD of images with requisition.
4. Upon completion of study,the documents will be scanned into PACS then stored in Digital library for 1 month prior to shredding.

Last Name: _____
First Name: _____
Date of Birth (YY/MM/DD): _____
Address: _____
City/Province/Postal Code: _____
Phone (Daytime): _____
Phone (Evening): _____
OHIP #: _____

## EXAM REQUESTED (be specific)

☐ Lung – solitary pulmonary nodule
☐ Lung – non-small cell cancer
☐ Lung – small cell cancer

☐ Lymphoma – staging of Hodgkin's/non-Hodgkin's
☐ Lymphoma – staging of follicular/other indolent
☐ Lymphoma – interim assessment (post 2-3 cycles)
☐ Lymphoma – post-therapy

☐ Colorectal – liver metastases
☐ Colorectal – recurrent (provide biomarkers)

☐ Esophageal – baseline staging
☐ Esophageal – post neo-adjuvant therapy

☐ H&N – SCC with unknown primary
☐ H&N – nasopharyngeal staging

☐ Melanoma
☐ Thyroid – recurrence (provide biomarkers)
☐ Germ cell – recurrence (provide biomarkers)

Other (Research): _____

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

## REFERRING PHYSICIAN

Signature: _____

Physician name: _____

Phone # _____

Copies of report to: _____

## CLINICAL HISTORY

M ☐ F ☐ Height (cm): _____ Weight (kg):_____
Diabetic: Yes ☐ No ☐
Medications: _____

**Please complete (if applicable):**

Relevant surgery: ☐ Yes ☐ No
Date: _____ Where on body? _____

Biopsy: ☐ Yes ☐ No
Date: _____ Biopsy site? _____

Chemo drug used: _____
# of cycles (completed / total): _____
Date of last cycle: _____

Radiation site(s): _____
Intent (radical/palliative): _____
Date of last treatment: _____

**Please provide the following** (check all that apply):

☐ CD with recent CT / MR scans
☐ CT / MR imaging report
☐ Relevant consultation letter
☐ Pathology / biopsy report

**Patients MUST fast for 4 hours prior to test and bring a medication list to their appointment.**

Appointment date: _____

Appointment time:: _____