

PET / CT REQUISITION

Phone: (519) 254-1727 Fax request to: (519) 254-4759

**This request MUST BE SUBMITTED along with the associated PET CCO requisition found on
PET SCAN ONTARIO website www.CCOHEALTH.CA/PET
INCOMPLETE / ILLEGIBLE REQUESTS WILL BE RETURNED - Resulting in delay of appointment booking**

| PATIENT INFORMATION (PLEASE PRINT) | | | |
|---|-------------------------|---|--|
| For patients who may benefit from PET, but who do not meet the eligibility criteria, please visit the website www.CCOHEALTH.CA/PET to download forms for the PET Access Program and obtain information regarding currently available clinical trials. | | | |
| Name: | DOB (dd/mm/yyyy): | Gender: | Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Last | First | | |
| Primary Contact #: | Alternate #: | Height: | Weight: |
| Address: | | <input type="checkbox"/> Ambulatory | <input type="checkbox"/> Wheelchair <input type="checkbox"/> Stretcher |
| Health Card # | Version Code: | <input type="checkbox"/> Claustrophobic <input type="checkbox"/> Interpreter Required | |
| Drug/Contrast Allergies: | | | |
| <input type="checkbox"/> Diabetes Mellitus Diabetic Medications: | | | |
| INSURED SERVICES: SEE www.CCOHEALTH.CA/PET FOR DETAILED ELIGIBILITY CRITERIA | | | |
| GASTROINTESTINAL CANCERS | | GENITOURINARY (GU) CANCERS | |
| <input type="checkbox"/> Esophageal or GE Junction (Staging / Re-staging) | | <input type="checkbox"/> Germ Cell Tumours (Biochemical Recurrence) | |
| <input type="checkbox"/> Colorectal (Biochemical Recurrence) | | <input type="checkbox"/> Seminoma (Residual Mass) | |
| <input type="checkbox"/> Colorectal (Apparent Limited Metastatic) | | | |
| <input type="checkbox"/> Anal Canal (Staging) | | | |
| GYNECOLOGICAL CANCERS | | HEAD AND NECK CANCERS | |
| <input type="checkbox"/> Locally Advanced Cervical Cancer (Staging) | | <input type="checkbox"/> Thyroid (Biochemical Recurrence) | |
| <input type="checkbox"/> Gynecologic Cancer (Recurrent, Prior to Salvage Therapy) | | <input type="checkbox"/> Nasopharyngeal (Baseline staging) | |
| | | <input type="checkbox"/> Head & Neck node positive (Baseline Staging) | |
| | | <input type="checkbox"/> Unknown Head and Neck Primary | |
| | | <input type="checkbox"/> Head & Neck (Re-staging After Chemo Radiation Therapy) | |
| LYMPHOMA | | THORACIC CANCERS | |
| <input type="checkbox"/> Staging PET for Hodgkin's Lymphoma | | <input type="checkbox"/> Lung – solitary pulmonary nodule (SPN) | |
| <input type="checkbox"/> Staging PET for Aggressive Non-Hodgkin's Lymphoma | | <input type="checkbox"/> Lung – non small cell cancer (NSCLC; clinical stage I – III) | |
| <input type="checkbox"/> Staging PET for Indolent Lymphoma | | <input type="checkbox"/> Lung – small cell lung cancer (SCLC; clinical stage I – III) | |
| <input type="checkbox"/> Interim Response PET for Hodgkin's Lymphoma | | <input type="checkbox"/> Mesothelioma – staging | |
| <input type="checkbox"/> End of Therapy Response Assessment PET | | | |
| DERMATOLOGY | | | |
| <input type="checkbox"/> Melanoma (Staging of localized high risk, or isolated Metastases) | | | |
| REGISTRY: SEE www.CCOHEALTH.CA/PET FOR DETAILED ELIGIBILITY CRITERIA | | | |
| 1. Multiple Myeloma/Plasmacytoma | | 2. Sarcoma | |
| <input type="checkbox"/> Plasmacytoma | | <input type="checkbox"/> Diagnosis (Plexiform Neurofibromas) | |
| <input type="checkbox"/> Smoldering Myeloma | | <input type="checkbox"/> Initial Staging | |
| <input type="checkbox"/> Non-Secretory / Oligosecretory Myeloma | | <input type="checkbox"/> Re-staging | |
| Cancer Treatment | | | |
| <input type="checkbox"/> Chemotherapy | Start Date(mm/dd/yyyy): | Last Date(mm/dd/yyyy): | Next Date (mm/dd/yyyy): |
| <input type="checkbox"/> Radiotherapy | Body Site: | Start Date(mm/dd/yyyy): | Last Date (mm/dd/yyyy): |
| Surgeries | | | |
| <input type="checkbox"/> Biopsy **Attach reports** | Body Site: | Date (mm/dd/yyyy): | |
| <input type="checkbox"/> Oncologic Surgery | Body Site: | Date (mm/dd/yyyy): | |
| <input type="checkbox"/> Other Surgery (within 3 months) | Body Site: | Date (mm/dd/yyyy): | |
| OUTSIDE IMAGING (PET/CT, CT, MRI) **Attach All Relevant Reports** Date: _____ Location: _____ (mm/dd/yyyy) | | | |
| Referring Physician (Print): | | Fax #: | Office #: |
| Signature: | | Physician Copies: | |
| PATIENT APPOINTMENT DATE (mm/dd/yyyy): _____ | | TIME: _____ | <input checked="" type="checkbox"/> MET CAMPUS |