

## PET / CT REFERRAL FORM

Please complete all sections and send to the Nuclear Medicine PET/CT fax at 519 646-6135

### 1. PATIENT INFORMATION

Last Name: \_\_\_\_\_  
 First Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
DD/MMM/YYYY  
 Health Card No.: \_\_\_\_\_ Version: \_\_\_\_\_  
 Height: \_\_\_\_\_ cm Weight: \_\_\_\_\_ kg

### 2. REFERRING PHYSICIAN INFORMATION

Referring Physician Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Billing No.: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Fax: \_\_\_\_\_  
 Family Physician: \_\_\_\_\_  
 Physician Signature: \_\_\_\_\_

3. RESEARCH STUDY?  No  Yes R# \_\_\_\_\_ LORA# \_\_\_\_\_ Study Name \_\_\_\_\_ Research lead: \_\_\_\_\_

### 4. REASON FOR REFERRAL

**Insured Services:**

- |   |  |
|---|--|
| <input type="checkbox"/> Post-therapy lymphoma  | <input type="checkbox"/> Liver metastasis from colorectal cancer |
| <input type="checkbox"/> Non-small Cell Lung Cancer                                       | <input type="checkbox"/> Solitary Pulmonary Nodule (SPN)         |
| <input type="checkbox"/> Thyroid cancer   | <input type="checkbox"/> Limited disease small cell lung cancer  |
| <input type="checkbox"/> Germ cell tumours  | <input type="checkbox"/> Colorectal cancer                       |
| <input type="checkbox"/> Metastatic squamous cell carcinoma<br>– evaluation of neck nodes | <input type="checkbox"/> Esophageal cancer                       |

**PET Registry:**

- Paediatric
- Melanoma
- Lymphoma (please attach registry forms)
- Staging of Hodgkin's or non-Hodgkin's 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 website [www.petscansontario.ca](http://www.petscansontario.ca) to download forms for the PET Access Program and to obtain information regarding currently available clinical trials.

### 5. Additional Clinical Information. *\*Please attach the most recent consult note if done outside of London, Ontario\**

COVID-19 vaccine received?  No  Yes **If yes**, Date of vaccination: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
Day Month Year

Vaccination site on body:  Left  Right Site:

Is the patient diabetic?  No  Yes **If yes**, list medications used to control patient's diabetes:

Has there been a biopsy?  No  Yes **If yes**, date and site of biopsy on body:

Has there been surgery?  No  Yes **If yes**, date, reason and site on body of surgery:

	List all dates:		Past dates	Present dates	Future dates
Radiation Therapy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			
Chemotherapy?	<input type="checkbox"/> No	<input type="checkbox"/> Yes			

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

- |                                   |   |  |  |  |
|-----------------------------------|---|--|--|--|
| <input type="checkbox"/> Tumor    | <input type="checkbox"/> Smoking          | <input type="checkbox"/> Asbestos Exposure         | <input type="checkbox"/> Stroke          | <input type="checkbox"/> Coronary Artery Disease |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Thyroid Disorder | <input type="checkbox"/> Liver Disease (Cirrhosis) | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Claustrophobia          |

If yes to any of the above, please provide details

Please list all current medications:

Nuclear Medicine use only: **PET scan appt** Date: \_\_\_\_\_ Time: \_\_\_\_\_