# NUCLEAR MEDICINE PET/CT REQUEST FORM

Referred by: (PLEASE PRINT)

ST JOSEPH'S HEALTH CARE LONDON

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

**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: _____

C**hemotherapy**: Please list all dates.

Past: _____ Present:_____ Future:_____

**Does the patient have a history of the following conditions**? Please circle 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**:_____