



POSITRON EMISSION TOMOGRAPHY (PET)

TO BE COMPLETED BY THE REFERRING PHYSICIAN

Tel.: (905) 855-1860 • Toll Free: 1-877-564-5227 • Fax: (905) 855-1863 • Toll Free Fax: 1-877-564-3297 • www.kmhlabs.com

Patient Demographics:

Surname: _____ First Name: _____ Middle Name: _____
 Sex: M F Province: _____ Postal Code: _____ Phone: (_____) _____ - _____
 OHIP Number: _____ Date of Birth: _____

PART 1 OHIP INSURED INDICATIONS

Solitary Pulmonary Nodule (SPN) due to:

- Failed Fine Needle Aspiration or other biopsy attempt, **OR**
- Medical condition(s) to establish diagnosis, **OR**
- Inaccessible to FNA

Non-Small Cell Lung Cancer (potentially resectable or candidate for curative combined therapy)

Stage: I II IIIA IIIB

Potentially Resectable Esophageal Cancer

- Staging **OR**
 Repeat PET/CT scan on completion of pre-operative/neoadjuvant treatment, prior to surgery

Stages:

TX T0 Tis T1 T1a T1b T2 T3 T4 T4a T4b
 NX N0 N1 N2 N3 M0 M1

Lymphoma Therapy Assessment (Complete 1 or 2)

1- Post Therapy Lymphomas:

- Residual Mass \geq 2 cm, **AND** Biopsy unable to be performed
 Hodgkin's (IPI Score) 0 - 7: _____, **OR**
 Non-Hodgkin's (IPI Score) 0 - 5: _____

2- Assessment or Response to Treatment (Hodgkin's Disease Only)

Chemotherapy to date: 2 Cycles completed, **OR** 3 Cycles completed
 Stage: IA or IIA (IPI Score) 0 - 7: _____

Colorectal Cancer (Complete 1 or 2)

- Recurrent Colorectal Cancer (Rising CEA)**
 Biomarker: _____ Value 1: _____ Value 2: _____
- Surgical candidate for hepatic metastectomy **AND** one or more of:**
 High risk surgical procedure
 High risk for surgery (ASA score \geq 4)

Recurrent Thyroid Cancer

Biomarker: _____ Value 1: _____ Value 2: _____

Recurrent Germ Cell Cancer

Biomarker: _____ Value 1: _____ Value 2: _____

Post treatment residual mass (Seminoma)

The patient must have:

- A. Received primary therapy, **AND**
 B. Recent imaging (CT, US, MR, or I-131 scanning) that is **negative or equivocal, AND**
 C. Biomarkers that are **elevated.**

Head & Neck Cancer (Complete 1 or 2)

Nasopharyngeal Cancer Staging

No known metastases in chest and abdomen

Neck Nodes Metastases with Unknown Primary

- Histologic confirmation of squamous cell carcinoma, **AND**
 Negative ENT physical exam for primary tumour, **AND**
 Negative CT and/or MRI of the neck.

Limited Disease Small Cell Lung Cancer

Stage: I II IIIA IIIB

Cardiac Viability

(Must Complete **CARDIAC OHIP** Req.)

PART 2 REGISTRY INDICATIONS

Anal Canal Cancer, with T2-T4 squamous cell carcinoma (Must Complete **REGISTRY** Req.)

Lymphoma Staging

(Choose 1 or 2 & Must Complete **REGISTRY** Req.)

- Staging of Hodgkin's Lymphoma or NHL being treated with curative intent.
- Apparent Limited Stage Nodal Follicular Lymphoma & other Indolent NHL for curative radiation therapy.

Melanoma

Purpose: Staging (Localized "High Risk" Tumours)

Evaluation of Isolated Metastasis

(choose 1 option from each column)

Lymph node metastases

Satellitosis or intransit metastases

Deep head and neck melanoma

Stage IIC

Stage III

Stage IV

PART 3 ACCESS INDICATIONS (Must Complete **ACCESS** Req.)

Preapproval Required Only By PET Imaging Centre

- Post Therapy Squamous-Cell Carcinoma of Head & Neck Cancer with Residual Mass**
 Locally Advanced Cervical Cancer
 Recurrent Gynecologic Malignancies

Preapproval Required By CCO

- Paraneoplastic Neurological Syndromes
 Mesothelioma
 Resectable Pancreatic Cancer
 Other

Preapproval Required By CCN

- Cardiac

Referring Physician Information:

Surname: _____

First Name: _____

Phone: (_____) _____ - _____ ext: _____

Fax: (_____) _____ - _____

Email: _____

CC: Physician: _____

Next Consult Date: _____

Last Treatment Date: _____

Next Treatment Date: _____

Billing #: _____ CPSO#: _____

Date: _____

Physician Signature

PET/CT – Patients Instructions

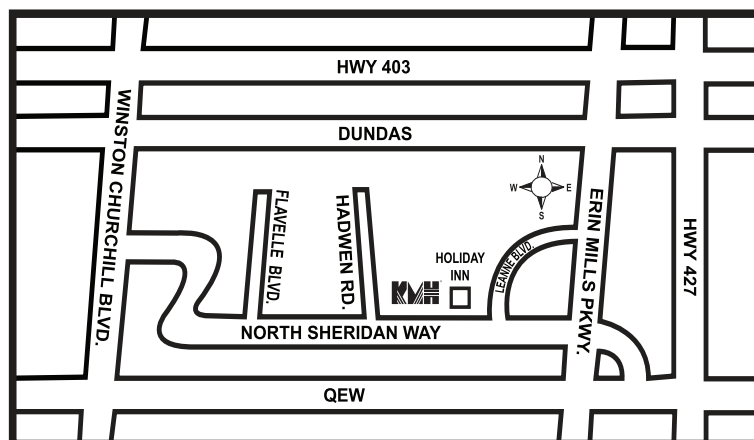
1. Please provide **accurate and current patient demographic information**, especially day and home telephone numbers so we may contact the patient to book their appointment.
2. Reason for performing the test, relevant clinical information, as well as reports from relevant previous diagnostic tests and surgical interventions must accompany the requisition to ensure the correct protocol is assigned by our Nuclear Medicine Physician.
3. To ensure a diagnostic examination, **the patient needs to fast for 6 hours prior to their appointment**. Drinking water is allowed and encouraged within fasting period. No exercise 48 hours prior to your PET Scan. For afternoon appointments, patients are permitted to have a light breakfast before the 6-hour fast.
4. A 12-hour fast may be required for specific cardiac indications of which the patient will be informed at the time of booking his/her appointment.

For patients with Diabetes:

5. Hyperglycemia (blood glucose level > 10-11 mmol/L) can significantly interfere with tumor imaging and lead to a suboptimal study. **Reasonable glycemic control should be achieved before referring diabetic patients for this test.**
6. Oral hypoglycemic medication (diabetic pills) should be discontinued the day of the test. Consideration will be made to schedule patients on oral hypoglycemic medication in the morning.
7. Patients can continue their routine administration of insulin with a light breakfast. (Referring physician may advise patients taking long acting insulin separately from their short acting insulin to only take short acting insulin if appropriate). Consideration will be made to schedule patients on insulin in the early afternoon.

Please follow the instructions below for the best test results:

1. Do not eat or drink anything except water 6 hours prior to your appointment. No chewing gum, candies and mints allowed the day of the test. No exercise 48 hours prior to your PET Scan. The test will take approximately 2 hours.
2. Drink 2-4 glasses of water before your appointment time.
3. Wear warm, loose, comfortable clothing, preferably without metal zippers or buttons on the day of your test.
4. Bring a list of all prescription medication you are taking currently.
5. You may take all your medications (EXCEPT diabetic medications) with water on the day of the test.
6. If you are diabetic, please follow specific instructions given to you by your referring physician.
7. If you are claustrophobic, you may ask your doctor to give you a sedative to use prior to the study. Please arrange to have a designated driver after use of sedatives.



KMH Cardiology Centres Inc.

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