

KMH 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) preclude(s) invasive intervention to establish diagnosis, **OR**
- ☐ Inaccessible to FNA

Note: PET is not indicated for the workup of pure ground glass nodules due to very low yield.

☐ Non-Small Cell Lung Cancer (Complete Sections A, B and C)

A. Reason for PET (choose one):

- ☐ Baseline Staging (new diagnosis) ☐ Re-staging (locoregional recurrence)

B. Clinical Stage: ☐ I ☐ II ☐ IIIA ☐ IIIB

C. ☐ Histological confirmation of NSCLC, **OR**

- ☐ Strong clinical and radiological suspicion of NSCLC (e.g., based on patient history and/or imaging)

☐ Esophageal /GE Junction Cancer

- ☐ Baseline Staging, **OR**
☐ Repeat PET/CT scan on completion of pre-operative/neoadjuvant treatment, prior to surgery, **OR**
☐ Re-staging (locoregional recurrence)

Clinical Stages: (Please provide T, N and M staging)

☐ TX ☐ T0 ☐ T1s ☐ 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: (Complete A, B and C)

A. ☐ Residual Mass or Lesion

B. ☐ Hodgkin's, **OR** ☐ Non-Hodgkin's

C. ☐ Date of end of last chemotherapy prior to PET: _____
YYYY-MM-DD

2. Interim Response to Treatment (Hodgkin's Disease Only)

A. Chemotherapy to date: ☐ 2 Cycles completed, **OR** ☐ 3 Cycles completed

B. Date of end of last chemotherapy prior to PET: _____
YYYY-MM-DD

☐ Colorectal Cancer (Complete 1 or 2)

1. ☐ Recurrent Colorectal Cancer (Primary therapy received & rising CEA after surgical resection and negative/equivocal imaging)

Elevated Biomarker: _____ Value 1: _____ Value 2: _____

2. ☐ Staging/Re-staging Colorectal Cancer

☐ Histologic confirmation of colorectal cancer, **AND**

☐ Presumptive pre-PET apparent limited metastatic disease or local recurrence, **AND**

☐ Patient has no significant comorbidities that would preclude radical intent therapy if clinically indicated.

☐ Thyroid Cancer Recurrence or Persistent Disease*

Biomarker: _____ Value 1: _____ Value 2: _____

☐ Germ Cell Tumour (Complete A & B)

A. ☐ Recurrent*, **OR** ☐ Seminoma (Post treatment residual mass)

B. Biomarker: _____ Value 1: _____ Value 2: _____

*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 or rising.

☐ Head & Neck Cancer (Complete 1 or 2)

1. ☐ Nasopharyngeal Cancer Staging

☐ No known metastases in chest and abdomen (by negative CT chest **and** negative CT or US abdomen)

2. ☐ 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

PART 2 REGISTRY INDICATIONS

☐ Lymphoma Staging (Choose one only)

☐ Hodgkin's Lymphoma

☐ Aggressive Non-Hodgkin's Lymphoma (specify histology): _____

☐ Indolent Lymphoma - where extent of disease will impact patient management (e.g., focal radiotherapy)

☐ Anal Canal Cancer, with T2-T4 squamous cell carcinoma

(Must Complete **REGISTRY** Req.)

☐ Sarcoma (Must Complete **REGISTRY** Req.)

☐ Multiple Myeloma/Plasmacytoma

(Must Complete **REGISTRY** Req.)

☐ Melanoma

Purpose: ☐ Staging of Localized High Risk Melanoma

(e.g., lymph node metastases, satellitosis or intransit metastases, or deep head and neck melanoma)

☐ Evaluation of Isolated Metastasis

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

Preapproval Required Only By PET Imaging Centre

- ☐ Head & Neck Cancer: Restaging H&N Cancer after Chemoradiotherapy
☐ Head & Neck Cancer: Baseline Staging Node Positive (N1-N3)
☐ Anaplastic Thyroid
☐ Medullary Thyroid
☐ Cervical Staging Cancer
☐ Gynecologic Cancer Recurrence

Preapproval Required By CCO

- ☐ Paraneoplastic Neurological Syndromes
☐ Mesothelioma
☐ Resectable Pancreatic Cancer
☐ Other

PART 4 CARDIAC PET (Must Complete **CARDIAC** Req.)

Preapproval Required By CCN

- ☐ Cardiac

Referring Physician Information:

Surname: _____

First Name: _____

Phone: (_____) _____ - _____ ext: _____

Fax: (_____) _____ - _____

Email: _____

C.C. Physician: _____

Next Consult Date: _____

Last Treatment Date: _____

Next Treatment Date: _____

Billing #: _____ CPSO #: _____

Date: _____

Physician Signature

Note: Please provide the most recent and relevant imaging report(s) (e.g. CT, MRI, US), and digital images (CD/DVD), and pathology report(s), if applicable. As radiation therapy & chemotherapy may affect the sensitivity of the PET scan, it is strongly recommended to schedule PET at least 6 weeks after last round of therapy, if possible.

PET/CT – Patients Instructions

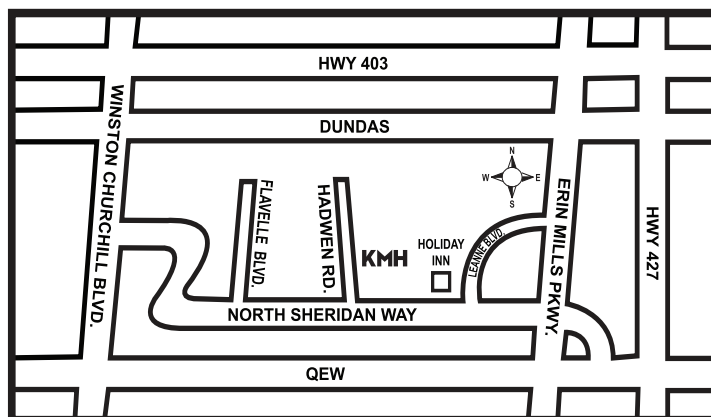
1. Please provide **accurate and current patient demographic information**, especially day and home telephone numbers, so we may contact the patient to book their appointment.
2. Reason for performing the test, relevant clinical information, as well as, reports from relevant previous diagnostic tests 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(s) you are currently taking.
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.



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