PET/CT
Request Form

St. Joseph's Healthcare Hamilton

Hamilton Health Sciences

St. Joseph's Hospital
Nuclear Medicine & Molecular Imaging Department
Fontbonne Building F-129
50 Charlton Avenue East
Hamilton, ON L8N 4A6
Phone: (905) 522-1155, Ext. 32746
Fax: (905) 308-7215

McMaster Hospital
Nuclear Medicine Department
1200 Main Street West
Hamilton, ON L8N 3Z5
Phone: (905) 521-2100 Ext. 75274
Fax: (905) 521-2358
(Pediatrics and Cardiac Viability Only)

LAST NAME:

FIRST NAME: D.O.B.: YY / MM / DD

ADDRESS:

CITY/PROV POSTAL CODE

PHONE: DAYTIME
EVENING

M ☐ **F** ☐

OHIP#:

DIABETIC: **YES** ☐ **No** ☐

DIABETIC MEDICATIONS: _____

Patient Height(cm):_____ Patient Weight(kg):_____

EXAM REQUESTED (be specific):

Insured Services:

- ☐ Cardiac **Perfusion** Scan (PET Only)
- ☐ Cardiac **Viability** Scan (PET Only)
- ☐ Colorectal Cancer, recurrent
- ☐ Esophageal Cancer
- ☐ Germ Cell Cancer, recurrent
- ☐ **Lung:** Non-Small Cell Cancer
- ☐ **Lung:** Limited Small Cell Cancer
- ☐ **Lung:** Solitary Pulmonary Nodule (SPN)
- ☐ **Lymphoma:** *Assess Treatment (post 2-3 cycles)*
- ☐ **Lymphoma:** *Residual Mass post therapy*
- ☐ Testicular Cancer, recurrent
- ☐ Thyroid Cancer, recurrent
  Date of I^{131} WB Scan: _____

Registry:

- ☐ Pancreatic Cancer
- ☐ Melanoma
- ☐ Cardiac Sarcoid

Other (Research): _____

For patients who may benefit from PET, but who do not meet the eligibility criteria, please visit the website www.petscansontario.ca to download forms for the PET Access Program and obtain information regarding currently available clinical trials.

Please provide the following: (check all that apply)

- CD with Recent CT Scans ☐
- Relevant Consultation Letter ☐
- CT / MRI Imaging Report ☐
- Pathology / Biopsy Report ☐

CLINICAL HISTORY

Please complete (if applicable):

Relevant Surgery: **YES** ☐ **No** ☐

Date: _____ Where on body? _____

Biopsy: **YES** ☐ **No** ☐

Date: _____ Biopsy site? _____

Chemo Drug Used: _____

Number of Cycles: _____

Date of Last Cycle: _____

Radiation Field: _____

Number of Treatments: _____

Date of last Treatment: _____

REFERRING PHYSICIAN

Signature:
_____

Printed name:
_____

Phone #:
_____

Copies of report to:

Patients **MUST** fast for 4 hours prior to test.

Appt. Date _____

Appt. Time _____

We Welcome your Referrals