

### 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)

#### 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<sup>131</sup> 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](http://www.petscansontario.ca) to download forms for the PET Access Program and obtain information regarding currently available clinical trials.

#### REFERRING PHYSICIAN

Signature: \_\_\_\_\_

Printed name: \_\_\_\_\_

Phone #: \_\_\_\_\_

Copies of report to: \_\_\_\_\_

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): \_\_\_\_\_

**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: \_\_\_\_\_

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

Appt. Date \_\_\_\_\_

Appt. Time \_\_\_\_\_

*We Welcome your Referrals*