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MyHealth | CENTRE

REQUEST FORM - ONCOLOGY
PET/CT DEPARTMENT

6870 Goreway Drive, Suite 101
Mississauga, ON L4V 1P1
Tel: 416-572-1725 | Fax: 1-888-761-9156
E: booking.petct@myhealthsecure.ca | www.myhealthcentre.ca

PATIENT INFORMATION:

PATIENT'S NAME: _____ D.O.B: _____ ☐ F ☐ M

ADDRESS: _____

TELEPHONE #: _____ OHIP #: _____

HEIGHT: _____ in WEIGHT: _____ lbs ALLERGIES: _____

DIABETIC: ☐ Yes ☐ No If yes, list meds: _____ **CLAUSTROPHOBIA:** ☐ Yes ☐ No

SPECIAL PRECAUTIONS: _____

NEXT APPOINTMENT DATE: _____ Check if applicable ☐ **STAT**

*Note: Please print clearly or attach patient label. Please fax completed form to **1-888-761-9156**

INSURED (OHIP) SERVICES

SOLITARY PULMONARY NODULE
- ☐ Failed biopsy attempt
- ☐ Contraindication to biopsy
- ☐ Inaccessible to FNA

NON-SMALL CELL LUNG CANCER
Stage: ☐ I ☐ II ☐ IIIA ☐ IIIB

SMALL CELL LUNG CANCER
Stage: ☐ I ☐ II ☐ IIIA ☐ IIIB

THYROID CANCER: recurrence, ↑ thyroglobulin ☐

GERM CELL TUMOURS: recurrence ☐

COLORECTAL CANCER
- ☐ Post-op recurrence and ↑ CEA
- ☐ Pre-op for high risk hepatic metastectomy:

Select risk categories below:
- ☐ High risk liver surgical procedure
- ☐ High risk patient (ASA score ≥ 4)

LYMPHOMA
IPI Score: _____ **[required]**
- ☐ **Residual mass post therapy** ☐ NHL ☐ Hodgkin's
- ☐ **Assess Response (Hodgkin's only)**

# of chemo cycles: ☐ 2 ☐ 3
Stage: ☐ IA ☐ IIA

ESOPHAGEAL CANCER
- ☐ Initial staging
- ☐ Repeat PET after pre-op/neoadjuvant treatment

HEAD AND NECK CANCER
- ☐ Nasopharyngeal cancer staging
- ☐ Evaluation of metastatic squamous cell carcinoma in neck nodes when **primary disease site is unknown**

PET REGISTRY

☐ **ANAL CANAL CANCER** ***(additional forms required)***

MELANOMA:
(select 3 boxes below)

Purpose: ☐ Evaluation of isolated met ☐ Staging
Reason: ☐ Lymph node metastases ☐ Satellitosis/intransit mets ☐ Deep H&N melanoma
Stage: ☐ IIC ☐ III ☐ IV

LYMPHOMA STAGING:
(additional forms required)
- ☐ Staging of Hodgkin's or NHL being treated with curative intent
- ☐ Staging of limited stage nodal follicular lymphoma & other indolent NHLs for curative radiation therapy

ACCESS AND PRIVATE PAY

PET ACCESS** ☐ ***fax req and additional forms to 416-217-1327

Private Billing ☐ *Indication:* _____

SUPPORTING CLINICAL INFORMATION

Recent Biopsy/Surgery: _____ Date: _____

Recent Chemo: _____ Date: _____

Recent Rad. Therapy: _____ Date: _____

Please include the following:
☐ Relevant consultation letters ☐ CT / MRI imaging reports ☐ Pathology / Biopsy reports

Clinical Information: _____

_____

_____

Referring Physician: _____ _____
Print Name Signature

CPSO #: _____ MOH Billing #: _____

Telephone: _____ Fax #: _____

Copy To: _____ Fax #: _____