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INITIO

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REQUEST FOR DIAGNOSTIC CT or PET/CT

• Patient Information •

Name		Date of Birth	____ / ____ / ____ DD MMM YYYY
Address		Care Card (PHN)	
City		E-mail	
Postal/Zip Code		Sex ☐ Male ☐ Female	
Phone Number		Weight lbs/kg	Height: ft'in/cm

• Examination Requested •

PET/CT ☐	FDG ☐	For DOTATATE scans: Is the patient on Somatostatin therapy?
CT only ☐	^{68}Gallium-DOTATATE ☐	☐ Yes ☐ No

• Clinical Indication(s) •

Does this patient have a known malignancy
☐ Yes ☐ No Type(s): _____

For Internal Use Only

Please include relevant reports

• Additional Patient Information •

Diabetic ☐ Yes ☐ No	Claustrophobic ☐ Yes ☐ No	Impaired Mobility ☐ Yes ☐ No
☐ Metformin ☐ Insulin	Allergies ☐ Yes ☐ No	Breast Feeding ☐ Yes ☐ No
Fasting BGL _____	Specify _____	Pregnant ☐ Yes ☐ No

• Relevant Diagnostic Imaging (Please attach reports of imaging) •

Previous PET Scan	☐ Yes ☐ No	Other Medical Imaging	☐ Yes ☐ No
Date of Scan		Type (MRI, bone scan, CT, etc)	
Hospital/Clinic		Hospital/Clinic	

• Treatments •

Chemotherapy ☐ Yes ☐ No	Surgery/Biopsy ☐ Yes ☐ No	Radiotherapy ☐ Yes ☐ No
____ / ____ / ____ DD MMM YYYY	____ / ____ / ____ DD MMM YYYY	____ / ____ / ____ DD MMM YYYY

• Referring Physician Information •

Name		Phone Number	
MSP #		Fax Number	
Signature		Email address	
CC copy to GP:		Date	

• Please fax completed form to 604.678.9279 or e-mail to info@initiomedical.ca •