

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	<input type="checkbox"/> Male <input type="checkbox"/> Female
Phone Number		Weight	lbs/kg Height: ft'in/cm
• Examination Requested •			
68-Ga-PSMA PET/CT <input type="checkbox"/>	Latest PSA _____ Date _____	Prostatectomy? Y / N Date _____	
	Nadir PSA _____ Date _____	Radiotherapy? Y / N Date _____	
	Initial PSA _____ Date _____	Hormone therapy? Y / N	
• Clinical Indication(s) • Choose one:			
<input type="checkbox"/> Newly diagnosed, clinically high risk, CT/MR Inconclusive. <input type="checkbox"/> Rising PSA (or never nadired) post-prostatectomy. Negative CT/MR. Salvage RT contemplated. <input type="checkbox"/> Rising PSA post RT but negative CT/MR. Salvage local or regional therapy contemplated. <input type="checkbox"/> Hormone sensitive metastases at diagnosis or post initial treatment. Scan may shift treatment intent. <input type="checkbox"/> CRPC with no known metastases. Change in clinical care contemplated.			
Does this patient have a known malignancy <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Type(s): _____ Prostate Gleason Score: _____ ECOG: _____			
• Additional Patient Information •			
Diabetic <input type="checkbox"/> Yes <input type="checkbox"/> No	Claustrophobic <input type="checkbox"/> Yes <input type="checkbox"/> No	Impaired Mobility <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Metformin <input type="checkbox"/> Insulin	Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No		
Fasting BGL _____	Specify _____		
• Relevant Diagnostic Imaging (Please attach reports of imaging) •			
Previous PET Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Medical Imaging	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Scan		Type (MRI, bone scan, CT, etc)	
Hospital/Clinic		Hospital/Clinic	
• Treatments •			
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Surgery/Biopsy <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiotherapy <input type="checkbox"/> Yes <input type="checkbox"/> 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 •			