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INITIO
NUCLEAR MEDICINE
DIAGNOSTICS · THERAPEUTICS · CLINICAL RESEARCH

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REQUEST FOR DIAGNOSTIC CT OR PET/CT

• Patient Information •

Name	hjd	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 •

68-Ga-PSMA PET/CT ☐	**Latest PSA** _____ **Date** _____ **Nadir PSA** _____ **Date** _____ **Initial PSA** _____ **Date** _____	**Prostatectomy? Y / N Date** _____ **Radiotherapy? Y / N Date** _____ **Hormone therapy? Y / N**

• Clinical Indication(s) • Choose one:

☐ Newly diagnosed, clinically high risk, CT/MR Inconclusive.
☐ Rising PSA (or never nadired) post-prostatectomy. Negative CT/MR. Salvage RT contemplated.
☐ Rising PSA post RT but negative CT/MR. Salvage local or regional therapy contemplated.
☐ Hormone sensitive metastases at diagnosis or post initial treatment. Scan may shift treatment intent.
☐ CRPC with no known metastases. Change in clinical care contemplated.

Does this patient have a known malignancy
☒ Yes ☐ No Type(s): **Prostate** **Gleason Score:** _____ **ECOG:** _____

• Additional Patient Information •

Diabetic ☐ Yes ☐ No ☐ Metformin ☐ Insulin Fasting BGL _____	Claustrophobic ☐ Yes ☐ No Allergies ☐ Yes ☐ No Specify _____	Impaired Mobility ☐ 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 •