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INITIO
NUCLEAR MEDICINE
DIAGNOSTICS - THERAPEUTICS - CLINICAL RESEARCH

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Request for Diagnostic 68-Ga-PSMA PET/CT Scan for Prostate Cancer

● Patient Information ●			
Name		Date of Birth	_____/ _____/ _____ DD MMM YYYY
Address		Care Card (PHN)	
City		E-mail	
Postal / Zip Code		Weight	lbs/kg
Phone Number		Height	ft'in/cm

● Clinical Indication(s) ●	
Diagnosed with prostate cancer, with Gleason _____ and ECOG _____	
Indication	☐PSA recurrence post-prostatectomy/HIFU/Brachytherapy ☐High risk prostate cancer for staging ☐Other: _____

● PSA Levels ●		
Initial PSA		Date
Nadir PSA		Date
Latest PSA		Date
	☐ This test is known to have reduced sensitivity when PSA <0.5. By checking this box, I indicate I understand and accept the increased risk of a false negative study, and I have explained this to the patient who also understands and accepts this risk.	

● Treatments ●		
Prostatectomy	☐Yes ☐No	Date
Radiotherapy	☐Yes ☐No	Date
Hormone Therapy	☐Yes ☐No	Date
Chemotherapy	☐Yes ☐No	Date

● Additional Patient Information ●			
Claustrophobic	☐Yes ☐No	Impaired Mobility	☐Yes ☐No

●Relevant Diagnostic Imaging (Please attach reports of imaging) ●			
Previous PET/CT Scan	☐Yes ☐No	Other Medical Imaging	☐MRI ☐ CT ☐Bone Scan
Date of Scan		Date of Scan	
Hospital / Clinic		Hospital / Clinic	

● Referring Physician Information ●			
Name		Phone Number	
MSP #		Fax Number	
Signature		Email Address	
CC Copies to		Date	

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