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INITIO
NUCLEAR MEDICINE
DIAGNOSTICS - THERAPEUTICS - CLINICAL RESEARCH

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Request for Lu-177 PSMA Therapy for Metastatic Castration Resistant Prostatic Carcinoma

● 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 Eligibility ●	
1. Confirmed diagnosis of mCRPC	☐ Yes ☐ No
2. Patient has received at least one ARPI and one taxane-based chemotherapy	☐ Yes ☐ No
3. Previous PSMA PET/CT in past 3 months	☐ Yes (Please send diagnostic images and report) ☐ No. Please perform at INITIO. *(Please fill Part A)* ☐ No, but we will obtain PSMA scan separately.
4. Previous FDG PET/CT scan in past 3 months *FDG PET/CT strongly recommended to detect disease not targetable with Lu-PSMA for prognostic purposes	☐ Yes (Please send diagnostic images and report) ☐ No. Please perform at INITIO. *(Please fill Part B)* ☐ No, but we will obtain FDG scan separately.

● Lab Results ●					
CBC with differential	Please attach report	BUN		ALT	
Albumin		Creatinine		AST	
Total Bilirubin		eGFR		ALP	
Latest PSA		Nadir PSA		Initial PSA	

● Part A – Request for PSMA PET/CT scan ●				
Prostatectomy	☐Yes ☐No	Date	Gleason	
Radiotherapy	☐Yes ☐No	Date	Other Medical Imaging (Please attach reports) ☐MRI ☐ CT ☐Bone Scan	
Hormone Therapy	☐Yes ☐No	Date		

● Part B - Request for FDG PET/CT Scan ●					
Diabetic	☐ Yes ☐No	Metformin	☐ Yes ☐No	Insulin	☐ Yes ☐No

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

● Referring Physician Information ●			
By signing below, I accept patient monitoring of post-radionuclide therapy, PSA, CBC, renal and hepatic function.			
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 ●