

## Request for Diagnostic 68-Ga-PSMA PET/CT Scan

● Patient Information ●			
Name		Date of Birth	____/____/____ <small>DD          MMM          YYYY</small>
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 (Select One)	<input type="checkbox"/> Initial staging of newly diagnosed prostate cancer <input type="checkbox"/> Biochemical (PSA) recurrence of treated prostatic carcinoma <input type="checkbox"/> Other (e.g. mCRPC): _____		
● PSA Levels ●			
Initial PSA		Date	
Nadir PSA		Date	
Latest PSA		Date	
	<input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	
Radiotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	
Hormone Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date	
● Additional Patient Information ●			
Claustrophobic	<input type="checkbox"/> Yes <input type="checkbox"/> No	Impaired Mobility	<input type="checkbox"/> Yes <input type="checkbox"/> No
● Relevant Diagnostic Imaging (Please attach reports of imaging) ●			
Previous PET/CT Scan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other Medical Imaging	<input type="checkbox"/> MRI <input type="checkbox"/> CT <input type="checkbox"/> 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 Copy to GP		Date	
● Please fax completed form to 604.678.9279 or e-mail to info@initiomedical.ca ●			