Eastern Health
Diagnostic Imaging

Request for Positron Emission Tomography (PET) Imaging (Part I)

IV2490 1556 01 2017

Allergies: ❑ No Known

Name: _____

HCN: _____

Date of Birth: DD/MONTH/YYYY

Address: STREET, TOWN, POSTAL CODE

Telephone: _____

❑ Inpatient – Unit _____ ❑ Outpatient

Patient Transport: ❑ Bed ❑ Stretcher ❑ Wheelchair

❑ MCP ❑ WCC ❑ NR ❑ DVA ❑ DND ❑ Other: _____

Physician Information (please use stamp)

The ordering physician is responsible to follow-up on the exam report.

Physician Signature: _____

Date: DD/MONTH/YYYY

Copy report to (please print): _____

Indications for Study

❑ Staging ❑ Assess Treatment Response

❑ Restaging ❑ Indeterminate Solitary Pulmonary Nodule

❑ Characterize Mass/Lesion

❑ Other (Specify): _____

Identify Urgency

Based on clinical assessment, Nuclear Medicine Physician consult may be indicated.

❑ Urgent ❑ Non-urgent

❑ Follow-up (Specify Date): DD/MONTH/YYYY

Clinical History: _____

Have you made the patient aware that the FDG used for their PET scan is being produced under a clinical trial? ❑ Yes ❑ No

Suspected Diagnosis: _____ Patient Medications: _____

Treatment History

	Yes	No	Start Date	Completed
Radiotherapy:	❑	❑	DD/MONTH/YYYY	DD/MONTH/YYYY
Chemotherapy:	❑	❑	DD/MONTH/YYYY	DD/MONTH/YYYY
Marrow Stimulant Therapy:	❑	❑	DD/MONTH/YYYY	DD/MONTH/YYYY
Other:	❑	❑	DD/MONTH/YYYY	DD/MONTH/YYYY

	Procedure	Date
Surgery/Biopsy:	_____	DD/MONTH/YYYY
Surgery/Biopsy:	_____	DD/MONTH/YYYY
Surgery/Biopsy:	_____	DD/MONTH/YYYY

Relevant Previous Imaging

(PET / Computed Tomography / Magnetic Resonance Imaging)

Exam	Date	Location
_____	DD/MONTH/YYYY	_____
_____	DD/MONTH/YYYY	_____
_____	DD/MONTH/YYYY	_____
_____	DD/MONTH/YYYY	_____
_____	DD/MONTH/YYYY	_____

Complete for Exams Requiring IV Contrast

Are there any of the following risk factors for contrast induced nephropathy (CIN)? ❑ Yes ❑ No

Risk Factors: Age greater than 70 years, Diabetes Mellitus, renal disease, Nephrotoxic drugs, organ transplant, chemotherapy, cardiovascular disease, single kidney.

If risk factor is present, please provide the patient's current* estimated GFR _____

Date of last GFR: DD/MONTH/YYYY

**Outpatient: less than 6 months; Inpatient: less than 7 days*

Safety Checklist

Can patient lie still/supine for 30 minutes? ❑ Yes ❑ No

Is patient incontinent? ❑ Yes ❑ No

Is patient claustrophobic? ❑ Yes ❑ No

Is patient diabetic? ❑ Yes ❑ No

❑ Type I Insulin Type(s): _____

❑ Type II ❑ Controlled by Diet Alone

❑ Oral Hypoglycemics (specify) _____

❑ Insulin (specify) _____

For Diagnostic Imaging Use Only

Ordering Physician Notified: ❑ *Phone* ❑ *Message* ❑ *Mail*

Date Received: DD/MONTH/YYYY

Patient Preparation Instructions: ❑ *Yes* ❑ *No*

Patient Notified: ❑ *Phone* ❑ *Message* ❑ *Mail*

IV Contrast: ❑ *Yes* ❑ *No* *Sedation:* ❑ *Yes* ❑ *No*

Nuclear Medicine Physician: _____

Date: DD/MONTH/YYYY

Priority: _____

Protocol: _____

_____

Name: _____ *Signature:* _____

Eastern Health
Diagnostic Imaging

Request for Positron Emission Tomography (PET) Imaging (Part II)

For all those referring patients for ^{18}F-FDG PET/CT scans:

We have begun local production of ^{18}F-Fluorodeoxyglucose (^{18}F-FDG) at the Health Sciences Center, in the Nuclear and Molecular Medicine Department for the performance of 18F-FDG Positron Emission Tomography (PET) scans. As per Health Canada guidelines, this requires the performance of a clinical trial. As part of the clinical trial, all patients will be required to give informed consent prior to the administration of ^{18}F-FDG with the primary indication being assessment of Adverse Events (AE) related to ^{18}F-FDG. There will also be a secondary indication to evaluate the efficacy of ^{18}F-FDG PET/CT in the assessment of Solitary Pulmonary Nodules (SPN). Data related to these indications will be recorded.

We ask all referring physicians to inform their patients about the existence of the clinical trial prior to ordering the study, and they will be receiving a copy of the informed consent form prior to their arrival for their study, so they won't be unduly concerned by it upon arrival. They will then be able to familiarize themselves with the document, and we will provide contact information for our clinical trial nurse, so they can contact him/her with any concerns they may have. We are anticipating doing this via email in some circumstances when time does not allow for the document to be mailed, so our booking clerk will be obtaining this information during the booking procedure. If patients prefer to receive this information in the mail, that can be done, however only if there is sufficient time prior to their appointment.

Since informing patients of the clinical trial is required by the Health Research Ethics Board (HREB) prior to enrolling them in the study, the research staff must have confirmation of this, prior to sending the patients their information package. We ask that you fill in the new check box on the requisition once you have discussed this with your patient. Consenting the patient is not required, this will be completed by our research staff. All requests, for both inpatients and outpatients, will now require this requisition to be filled out in its entirety.

We thank you in advance for your cooperation.

Dr. Jeffery Flemming, M.D., FRCPC Nuclear Medicine and Radiology
Clinical Chief, Nuclear and Molecular Medicine