St. Joseph's Hospital
Nuclear Medicine Program
268 Grosvenor St., P.O. Box 5777, Stn. B
London, ON N6A 4V2
Tel. 519-646-6000 ext. 61385
Fax. 519-646-6135

PET / CT REFERRAL FORM

Please complete all sections and send to the Nuclear Medicine PET/CT **fax at 519 646-6135**

1. PATIENT INFORMATION

Last Name: _____

First Name: _____

Address: _____

City: _____ Postal Code: _____

Phone: _____ Date of Birth: _____ *DD/MMM/YYYY*

Health Card No.: _____ Version: _____

Height: _____ cm Weight: _____ kg

2. REFERRING PHYSICIAN INFORMATION

Referring Physician Name: _____

Address: _____

City: _____ Postal Code: _____

Billing No.: _____

Phone: _____

Family Physician: _____

Physician Signature: _____

3. RESEARCH STUDY? ☐ No ☐ Yes R# _____ LORA#_____ Study Name _____ Research lead: _____

4. REASON FOR REFERRAL

Insured Services:

- ☐ Post-therapy lymphoma
- ☐ Non-small Cell Lung Cancer
- ☐ Thyroid cancer
- ☐ Germ cell tumours
- ☐ Metastatic squamous cell carcinoma – evaluation of neck nodes
- ☐ Liver metastasis from colorectal cancer
- ☐ Solitary Pulmonary Nodule (SPN)
- ☐ Limited disease small cell lung cancer
- ☐ Colorectal cancer
- ☐ Esophageal cancer

PET Registry:

- ☐ Paediatric
- ☐ Melanoma
- ☐ Lymphoma (please attach registry forms)
- ☐ Staging of Hodgkin's or non-Hodgkin's lymphoma
- ☐ Staging of nodal follicular lymphoma or other indolent non-Hodgkin's lymphomas

*For patients who may benefit from PET, but who do not meet the eligibility criteria, please visit the website www.petscansontario.ca to download forms for the **PET Access Program** and to obtain information regarding currently available **clinical trials**.*

5. Additional Clinical Information. ***Please attach the most recent consult note if done outside of London, Ontario***

COVID-19 vaccine received? ☐ No ☐ Yes **If yes,** Date of vaccination: _____/_____/_____ *Day / Month / Year*

Vaccination site on body: ☐ Left ☐ Right Site:

Is the patient diabetic? ☐ No ☐ Yes **If yes,** list medications used to control patient's diabetes:

Has there been a biopsy? ☐ No ☐ Yes **If yes,** date and site of biopsy on body:

Has there been surgery? ☐ No ☐ Yes **If yes,** date, reason and site on body of surgery:

	List all dates:		**Past dates**	**Present dates**	**Future dates**
Radiation Therapy?	☐ No	☐ Yes			
Chemotherapy?	☐ No	☐ Yes			

Does the patient have a history of any the following conditions? Please check all that apply.

☐ Tumor ☐ Smoking ☐ Asbestos Exposure ☐ Stroke ☐ Coronary Artery Disease

☐ Seizures ☐ Thyroid Disorder ☐ Liver Disease (Cirrhosis) ☐ Memory Problems ☐ Claustrophobia

If yes to any of the above, please provide details

Please list all current medications:

Nuclear Medicine use only: **PET scan appt** Date: Time: