Email to KMH | Print Form

KMH CARDIOLOGY & DIAGNOSTIC CENTRES

Website: www.kmhlabs.com • 905-855-1860 • 1-877-KMH-LABS (564-5227) • Fax: 905-855-1863

PET/CT - Oncology Insured & Registry

TO BE COMPLETED BY THE REFERRING PHYSICIAN

***Complete & submit PARTS 1- 4 as applicable and PART 5 for all requests

1. Please complete form and fax to KMH
2. See page 3 for completion instructions

Patient Demographics:

Surname: _____ First Name: _____ Middle Name: _____

Sex: ☐ M ☐ F Province: _____ Postal Code: _____ Phone: (____) ____ -_____

OHIP Number: _____ Date of Birth: _____ YYYY - MM - DD

PART 1 OHIP INSURED INDICATIONS

Eligibility for PET/CT for Undiagnosed Solitary Pulmonary Nodule (SPN) due to:

1. ☐ Failed Fine Needle Aspiration (FNA) or other biopsy attempt
2. ☐ Medical condition(s) preclude(s) invasive intervention to establish diagnosis
3. ☐ SPN inaccessible to FNA

Eligibility for PET/CT for Non-Small Cell Lung Cancer, Potentially Resectable or Candidate for Curative Combined Therapy

Indicate Pre-PET Stage: ☐ Clinical Stage I ☐ Clinical Stage II ☐ Clinical Stage IIIA ☐ Clinical Stage IIIB

Attach CT report and provide images on film or CD Other information regarding eligibility: _____

Eligibility for PET/CT for Small Cell Lung Cancer, Potentially Resectable or Candidate for Curative Combined Therapy

Indicate Pre-PET Stage: ☐ Clinical Stage I ☐ Clinical Stage II ☐ Clinical Stage IIIA ☐ Clinical Stage IIIB

Attach CT report and provide images on film or CD Other information regarding eligibility: _____

Eligibility for PET/CT for Lymphoproliferative Disorders

Post Therapy Lymphomas: ☐ Residual Mass ≥ 2 cm, **AND** ☐ Biopsy unable to be performed

☐ Hodgkin's International Prognostic Index Score (IPI Score) 0 - 7: _____ , **OR**

☐ Non-Hodgkin's International Prognostic Index Score (IPI Score) 0 - 5: _____

Assessment of Response to Treatment (Hodgkin's Disease Only)

Chemotherapy to date: ☐ 2 Cycles completed, **OR** ☐ 3 Cycles completed

Hodgkin's: ☐ Stage IA or ☐ Stage IIA International Prognostic Index Score (IPI Score) 0 - 7: _____

Eligibility for PET/CT for the following indication:

Last **two** biomarker results

☐ possible **recurrent thyroid cancer** Biomarker: _____ Value 1: _____ Value 2: _____

☐ possible **recurrent colorectal cancer** Biomarker: _____ Value 1: _____ Value 2: _____

☐ possible **recurrent germ cell cancer** Biomarker: _____ Value 1: _____ Value 2: _____

Other information regarding eligibility: _____

The patient must have:

A. Received primary therapy, **AND**

B. Recent imaging (CT, US, MR, or I131 scanning) that is **negative or equivocal, AND**

C. Biomarkers that are **elevated**

PART 2 REGISTRY INDICATIONS

Eligibility for PET/CT for Potentially Resectable Esophageal cancer

The patient must be eligible for surgery based upon conventional imaging. Attach CT report and endoscopic ultrasound report.

CT images must be provided to the PET/CT Centre on CD or film. Purpose: ☐ Staging

Esophageal Cancer - Clinical Stages:

☐ TX ☐ T0 ☐ Tis ☐ T1 ☐ T1a ☐ T1b ☐ T2 ☐ T3 ☐ T4 ☐ T4a ☐ T4b ☐ NX ☐ N0 ☐ N1 ☐ N2 ☐ N3 ☐ M0 ☐ M1

Eligibility for PET/CT for Potentially Resectable Pancreatic cancer

The patient must be eligible for surgery based upon conventional imaging. Attach CT report.

CT images must be provided to the PET/CT Centre on CD or film. Purpose: ☐ Staging

Pancreatic Cancer - Clinical Stages:

☐ TX ☐ T0 ☐ Tis ☐ T1 ☐ T2 ☐ T3 ☐ T4 ☐ NX ☐ N0 ☐ N1 ☐ M0 ☐ M1

Eligibility for PET/CT for Melanoma

Purpose: ☐ Staging ☐ Evaluation of Isolated Metastasis

(choose 1 option from each column)

☐ Lymph node metastases
☐ Satellitosis or intransit metastases
☐ Deep head and neck melanoma

☐ Clinical Stage IIC
☐ Clinical Stage III

Eligibility for PET/CT for Testicular Cancer

Purpose: ☐ Treatment response assessment

Post treatment residual mass ◯ Yes ◯ No

PET/CT - Oncology Access / Viability Insured & Access

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PART 3 ONTARIO PET/CT ACCESS PROGRAM

Diagnosis: (*please include topography, histology, clinical stage and pathological stage if known*)

____

____

Has histology been confirmed? ◯ Yes ◯ No

If no, reason why histology not confirmed:

____

PET/CT Scan Indications (check all that apply)

- ☐ Diagnosis
- ☐ Staging
- ☐ Prognostic value
- ☐ Risk stratification/response assessment
- ☐ Response-adapted therapy
- ☐ Surveillance/recurrence
- ☐ Restaging
- ☐ Treatment planning
- ☐ Other, (please specify): ______________________

How would PET/CT scan influence the clinical management of this patient? (check all that apply)

- ☐ Determine whether treatment vs. observation
- ☐ Determine whether to give curative vs. palliative treatment
- ☐ Determine whether surgery vs. chemotherapy/radiotherapy/combination
- ☐ If chemotherapy, determine single vs. combined treatment modality
- ☐ Determine whether to alter current therapy (continue, add, change dose or type)
- ☐ Other, (please specify): ______________________

If PET/CT scan is positive then patient management would be… ______________________

If PET/CT scan is negative then patient management would be... ______________________

What will a PET/CT scan demonstrate that cannot be proven by other means? ______________________

PART 4 ONTARIO CARDIAC FDG PET/CT IMAGING

IA. FDG PET/CT VIABILITY REQUIREMENTS (complete sections IA, II and III)

LVEF ≤ 40%   STATE EF = ______   NYHA ☐ II ☐ III ☐ IV

Candidate for revascularization or heart transplant ◯ Yes ◯ No

If the patient **DOES NOT** meet the above requirements, they may be eligible for viability or other FDG PET/CT imaging via *SPECIAL ACCESS*.

IB. SPECIAL ACCESS FDG PET/CT IMAGING (complete sections IB, II, III plus the *SPECIAL ACCESS* explanation)

CURRENT DIAGNOSIS: ☐ AORTITIS ☐ LVEF≥ 40% ☐ SARCOIDOSIS ☐ SARCOIDOSIS TREATMENT FOLLOW UP ☐ OTHER ______________

II. PRIOR CARDIAC IMAGING/TESTING COMPLETED (attach copies)

Stress perfusion	◯ Yes	◯ No	Stress Echo	◯ Yes	◯ No
Stress MRI	◯ Yes	◯ No	Coronary Angiogram	◯ Yes	◯ No
Cardiac CT Angiogram	◯ Yes	◯ No	Pulmonary testing	◯ Yes	◯ No
Thoracic CT	◯ Yes	◯ No	ECHO	◯ Yes	◯ No
MUGA	◯ Yes	◯ No	MRI	◯ Yes	◯ No

OTHER ______________________

If Stress Perfusion not previously done please indicate if it is required ◯ Yes ◯ No

III. PERTINENT CLINICAL INFORMATION (please indicate "Yes or No")

Diabetes	◯ Yes	◯ No	LBBB	◯ Yes	◯ No
MI in last 30 days	◯ Yes	◯ No	CABG	◯ Yes	◯ No
Previous PCI	◯ Yes	◯ No	Pacemaker	◯ Yes	◯ No
Renal Dysfunction	◯ Yes	◯ No	AICD	◯ Yes	◯ No
If yes, latest Cr. (UMOL/L) ______			CRT	◯ Yes	◯ No

IV. For CARDIAC SARCOID complete the following (check all that apply)

- ☐ Known Pulmonary/Systemic Sarcoid
- ☐ Heart Block ◯ Yes ◯ No
  - ☐ First Degree ☐ Second Degree ☐ Third Degree ☐ Candidate for pacemaker
- ☐ ECG Abnormality ◯ Yes ◯ No ☐ RBBB ☐ LBBB ☐ Other: ________
- ☐ Ventricular Arrhythmia ☐ Candidate for ICD
- ☐ Cardiomyopathy

For *SPECIAL ACCESS* please provide an explanation of how Cardiac FDG PET/CT will influence the clinical management of this patient.

____

Special Access Office Use Only   TRACKING NUMBER: ____________

Date of Request: [ ]   Scheduled Date of PET/CT Scan: [ ]

PART 5

For each eligibility criterion, please provide the most recent and relevant imaging report(s) (e.g. CT, MRI, US), and digital images (CD), and pathology report(s) if applicable.

Relevant Imaging studies included (indicate type of imaging):

☐ CT	☐ US	☐ MR	☐ Other, please specify: ______	Biomarker: ______	Value 1: ______	Value 2: ______	Date: YYYY - MM - DD
☐ CT	☐ US	☐ MR	☐ Other, please specify: ______	Biomarker: ______	Value 1: ______	Value 2: ______	Date: YYYY - MM - DD
☐ CT	☐ US	☐ MR	☐ Other, please specify: ______	Biomarker: ______	Value 1: ______	Value 2: ______	Date: YYYY - MM - DD
☐ CT	☐ US	☐ MR	☐ Other, please specify: ______	Biomarker: ______	Value 1: ______	Value 2: ______	Date: YYYY - MM - DD
☐ CT	☐ US	☐ MR	☐ Other, please specify: ______	Biomarker: ______	Value 1: ______	Value 2: ______	Date: YYYY - MM - DD
☐ CT	☐ US	☐ MR	☐ Other, please specify: ______	Biomarker: ______	Value 1: ______	Value 2: ______	Date: YYYY - MM - DD

Additional Comments: ______________________

Referring Physician Information:

Surname: ____________ First Name: ____________ Middle Name: ____________

CPSO: ____________ Phone: (____) ____ - ____ ext: ______ Fax: (____) ____ - ____

Email: ______________________ (Optional)

Physician Signature: ______________________ **Date:** [ ]

Fax Instructions: Please fax to **905-855-1863** the completed request form (PARTS 1- 4 as applicable and PART 5), along with the required previous imaging results.

PET/CT - Oncology Insured / Registry / Access / Viability

KMH would appreciate your assistance in following the procedures outlined below in order to minimize delays and expedite scheduling on PET/CT appointments.

1. Please provide **accurate and current patient demographic information**, especially day and home telephone numbers so we may contact the patient to book their appointment.
2. Reason for performing the test, relevant clinical information, as well as reports from relevant previous diagnostic tests and surgical interventions must accompany the requisition to ensure the correct protocol is assigned by our Nuclear Medicine Physician. Please ensure the CD for the appropriate imaging study is sent to KMH in order to fulfill OHIP eligibility criteria.
3. To ensure a diagnostic examination, **the patient needs to fast for 6 hours prior to their appointment**. Drinking water is allowed and encouraged within fasting period. For afternoon appointments, patients are permitted to have a light breakfast before the 6-hour fast.

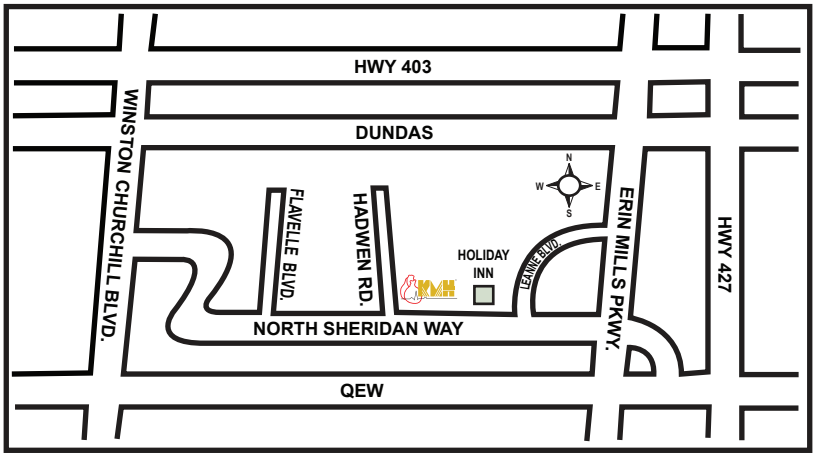
For patients with Diabetes:

4. Hyperglycemia (blood glucose level > 10-11 mmol/L) can significantly interfere with tumour imaging and lead to a suboptimal study. **Reasonable glycemic control should be achieved before referring diabetic patients for this test.**
5. Oral hypoglycemic medication (diabetic pills) should be discontinued the day of the test. Consideration will be made to schedule patients on oral hypoglycemic medication in the morning.
6. Patients can continue their routine administration of insulin with a light breakfast. (Referring physician may advise patients taking long-acting insulin separately from their short-acting insulin to only take short-acting insulin if appropriate). Consideration will be made to schedule patients on insulin in the early afternoon.

PATIENT INSTRUCTIONS

Please follow the instructions below for the best test results:

1. Do not eat or drink anything except water 6 hours prior to your appointment.
   No chewing gum, candies and mints allowed the day of the test.
   The test will last approximately 2 hours.
2. Drink 2-4 glasses of water before your appointment time.
3. Wear warm, loose, comfortable clothing, preferably without any metal zippers or buttons on the day of your test.
4. Bring a list of all prescription medication you are taking currently.
5. You may take all your medications (EXCEPT diabetic medications) with water on the day of the test.
6. If you are diabetic, please follow specific instructions given to you by your referring physician.
7. If you are claustrophobic, we may give you a sedative. Please arrange for transportation home.



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