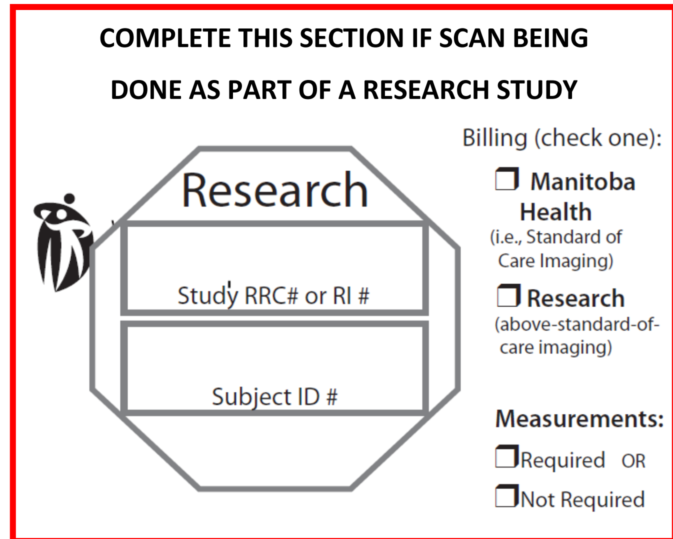
Great-West Life PET/CT Centre
Suite 751 - 7th Floor, John Buhler Research Centre
715 McDermot Ave, Winnipeg MB R3E 3P4
Phone: 787-3122 **FAX: 787-3300**

ONCOLOGY: Physician Referral Form



Patient Name ______________________________________

Birth date _______________ **PHIN** ____________________
(dd/mmm/yy)

HSC#____________________ **CR #**____________________

Home #_________________ **Cell #** ____________________

Address ____

____

Weight ____________ **kg** **Height** ___________ **cm**

Brief history, clinical diagnosis: ____

____

1. **DISEASE STATUS:**

a) Tumour Diagnosis

☐ Bladder	☐ Esophageal	☐ Lung	☐ Primary Unknown
☐ Brain	☐ Gastric	☐ Lymphoma	☐ Sarcoma
☐ Breast	☐ Gynecologic	☐ Melanoma	☐ Testicular
☐ Colorectal	☐ Head and Neck	☐ Myeloma	☐ Thyroid
☐ Other _________			

b) Primary Site: ____________________________ c) Histology: ____________________________

d) Previous Malignancies? ______________________________

2. **PRIMARY INDICATION:**

☐ Initial Staging of Proven Malignancy
☐ Characterize Mass/Lesion/Pulmonary Nodule
☐ Re-Staging
☐ Other : _________________________

☐ Assess **COMPLETION** of Treatment Response
☐ Assess **MIDDLE** of Treatment Response
Most recent chemo treatment date:_______________
Next planned chemo treatment date:_______________
(dd/mmm/yy)

3. **Please attach all relevant prior imaging reports (PET, MRI, CT etc.)**

4. Can patient manage with minimal assistance and look after personal needs? ☐ Yes ☐ No
Can patient lie supine for thirty minutes? ☐ Yes ☐ No
Can patient provide informed consent for the procedure? ☐ Yes ☐ No

5. **DIABETES**:
☐ No ☐ Diet only ☐ Medication-controlled ☐ Insulin-controlled

Physician Caring for Diabetes (please print) ________________________________

6. **CURRENT MEDICATIONS**: ____

____

____

7. **RELEVANT TREATMENT HISTORY:**

Treatment Type	Description of Treatment (please complete if report is not attached)	Completion Date (dd/mmm/yy)
Surgery		
Biopsy/Scope		
Chemotherapy		
Radiotherapy		

Referring Physician Name ______________________________ **Phone or Pager** __________________
(please print)

Referring Physician Signature: ______________________________ **Date:** ______________________________
(dd/mmm/yy)

--NUCLEAR MEDICINE USE ONLY--	
☐ **NEAR WHOLE BODY SCAN** ☐ **H&N & NWB** **ARMS Preference**: ☐ Up ☐ Down ☐ No Pref. **START:** ☐Eyes ☐ Top of head **STOP:** ☐ Mid-thigh ☐ Other_______________ ☐ **BRAIN** ☐ **WHOLE BODY (please select near whole body parameters)**	**LASIX** ☐ NO ☐ YES **ORAL CONTRAST** ☐ NO ☐ YES **D/C THYROID MEDS** ☐ NO ☐ YES___WK
PRIORITY ☐ 1 ☐ 2 ☐ 3	**Initials**__________

PRODUCT	ACTIVITY / AMOUNT	ROUTE	INJ. SITE	DATE	TIME	TECH
Telebrix 38 Oral	mls in mls water	Oral			h	
18F - FDG	MBq	I.V.			h	
Lasix	mg	I.V.			h	
Telebrix 38 Oral	mls in mls water	Oral			h	

Alternative I.V access particulars:____