Shared health Soins communs Manitoba

Health Sciences Centre Winnipeg
A Shared Health facility

PET-CT Requisition

Level 1 Green Owl Zone Room GH126
820 Sherbrook St, Winnipeg, MB R3A 1R9
Phone (204) 787-3122 Fax (204) 787-3300

MRN

SURNAME

GIVEN NAME

DATE OF BIRTH

MB FAMILY REG #

PHIN

Patient Address: _____

Patient Phone: Primary |_|_|_|-|_|_|_|-|_|_|_|_| Alternate |_|_|_|-|_|_|_|-|_|_|_|_|

Referral Date: D D M M M Y Y Y Y |_|_|_|_|_|_|_|_|

Referring Care Provider: _____ Contact Number |_|_|_|-|_|_|_|-|_|_|_|_|

Referring Facility: _____ Fax Number |_|_|_|-|_|_|_|-|_|_|_|_|

Patient weight: _____ kg Patient height: _____ cm

Complete this section if scan is part of a research study:	**Billing:** (check one)	☐ **Manitoba Health** (i.e. Standard of Care Imaging)	☐ **Research** (above Standard of Care Imaging)
	Measurements: ☐ Required OR ☐ Not Required		
	Study RRC # or RI #:		
	Subject ID #:		

1. HISTORY including clinical diagnosis and treatment: (attach relevant clinical/progress notes, imaging, pathology and lab reports)

_____

_____

2. REQUESTED PRIORITY ☐ less than 7 days ☐ 8–28 days ☐ 29–60 days ☐ specific date D D M M M Y Y Y Y |_|_|_|_|_|_|_|_|

3. TEST REQUESTED

☐ **F18 FDG** (complete sections a and b)

a) DIABETIC PATIENT (blood glucose level must be less than 10 mmol/L for the appointment with 4-6 h fasting)

☐ No ☐ Diet-controlled ☐ Medication-controlled ☐ Insulin-controlled ☐ Insulin pump

b) INDICATIONS

☐ **Cardiac Sarcoid** ☐ **Neurology** ☐ **Other** _____

☐ **Oncology** (select from options below)

☐ Staging of proven malignancy ☐ Re-staging of disease ☐ Characterize mass/lesion

☐ Chemotherapy response ☐ **MID** between Tx date _____ and next Tx date _____

☐ **END** of treatment, completion date _____

☐ **Ga68 Dotatate** Recent Chromogranin A result _____ ng/mL or ☐ pathology report **attached**

☐ **Ga68 PSMA** PSA level _____ and/or ☐ relevant imaging &/or pathology reports attached

Category: 1- ☐ Lu177 Tx eligibility **2-** ☐ Biochemical recurrence post prostatectomy **3-** ☐ Primary staging, high risk patient
4- ☐ For Trial eligibility **5-** ☐ Recommended by consult with GU case rounds

☐ **Other** Type of PET scan requested _____

4. a) Can patient manage with minimal assistance and look after personal needs? ☐ **Yes** ☐ **No**

b) Can patient lie supine for thirty minutes? ☐ **Yes** ☐ **No**

c) Can patient provide informed consent for the procedure? ☐ **Yes** ☐ **No**

If NO, alternate decision maker: _____ Phone number: _____

d) **Does patient require special booking considerations?** ☐ **Yes** ☐ **No**

☐ Oxygen use ☐ Minimally ambulatory/wheelchair bound ☐ Mechanical lift ☐ Pediatric, may require sedation

☐ Language translator needed, language required: _____

☐ Dialysis patient ☐ Other considerations: _____

Referring Care Provider: _____ _____
NAME SIGNATURE

ALL SECTIONS MUST BE COMPLETED OR REFERRAL WILL BE RETURNED