

St. Joseph's Hospital

Nuclear Medicine & Molecular
Imaging Department
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McMaster Hospital

Nuclear Medicine Department
1200 Main Street West
Hamilton, ON L8N 3Z5
Phone: (905) 521-2100 Ext. 75274
Fax: (905) 521-2358
(Pediatrics and Cardiac
Viability Only)

EXAM REQUESTED (be specific):

- Insured Services:** Cardiac Perfusion Scan (PET Only)
- Cardiac Viability Scan (PET Only)
- Colorectal Cancer, recurrent
- Esophageal Cancer
- Germ Cell Cancer, recurrent
- Lung: Non-Small Cell Cancer
- Lung: Limited Small Cell Cancer
- Lung: Solitary Pulmonary Nodule (SPN)
- Lymphoma: Assess Treatment (post 2-3 cycles)
- Lymphoma: Residual Mass post therapy
- Testicular Cancer, recurrent
- Thyroid Cancer, recurrent
- Date of I¹³¹ WB Scan: _____
- Registry:** Pancreatic Cancer
- Melanoma
- Cardiac Sarcoid

Other (Research): _____

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 obtain information regarding currently available clinical trials.

REFERRING PHYSICIAN

Signature: _____
Printed name: _____
Phone #: _____
Copies of report to: _____

LAST NAME: _____

FIRST NAME: _____ D.O.B.: _____
YY / MM / DD

ADDRESS: _____

CITY/PROV _____ POSTAL CODE _____

PHONE: DAYTIME _____
EVENING _____ M F

OHIP#: _____

DIABETIC: YES No

DIABETIC MEDICATIONS: _____

Patient Height(cm): _____ Patient Weight(kg): _____

Please provide the following: (check all that apply)

- CD with Recent CT Scans
- Relevant Consultation Letter
- CT / MRI Imaging Report
- Pathology / Biopsy Report

CLINICAL HISTORY

Please complete (if applicable):

Relevant Surgery: YES No

Date: _____ Where on body? _____

Biopsy: YES No

Date: _____ Biopsy site? _____

Chemo Drug Used: _____

Number of Cycles: _____

Date of Last Cycle: _____

Radiation Field: _____

Number of Treatments: _____

Date of last Treatment: _____

Patients **MUST** fast for 4 hours prior to test.

Appt. Date _____
Appt. Time _____

We Welcome your Referrals