PET – CT REQUISITION FORM
Royal University Hospital
103 Hospital Drive
Saskatoon, SK S7N 0W8
Phone: (306) 655-3340
Fax: (306) 655-1635

Last Name: ___________________________ First Name: ___________________________
D.O.B. ___________________ Address: ___________________________________________
City/Province __________________ Postal Code: ___________________________
Phone: ____________________________ __________________ Provincial Health #: ____________
Home Phone: ____________________________ Cell Phone: ____________________________
Patient Height: _______________ Weight: _______________ Patient Diabetic: Yes No
Referring Physician: ____________________________ Phone: ____________________________ Fax: ____________________________

Reason for Request:
[ ] Malignancy (known primary) [ ] Neurologic
[ ] Malignancy (unknown primary) [ ] Inflammation/Infection
[ ] Cardiac

Malignancy (known primary):
[ ] Anus [ ] Stomach [ ] Lymphoma (Non-Hodgkin’s)
[ ] Breast/female [ ] Testicular [ ] Melanoma
[ ] Breast/male [ ] Thymus/heart [ ] Myeloma
[ ] Bone [ ] Thyroid [ ] Nasal cavity/ear/sinus
[ ] Cervix [ ] Uterine/endometrial [ ] Ovary
[ ] Colon/rectum [ ] Sarcoma [ ] Pancreas
[ ] Connective or other soft tissue [ ] Larynx [ ] Primary brain
[ ] Esophagus [ ] Liver [ ] Prostate (non-adenocarcinoma)
[ ] Gallbladder/bile ducts [ ] Lung, non-small cell [ ] Other (please describe):
[ ] Retroperitoneum [ ] Lung, small cell (limited)
[ ] Small intestine [ ] Leukemia

Malignancy (unknown primary):
Proven or strongly suspected metastatic disease. Please select the suspected malignancy.

[ ] Bone/marrow [ ] Lymph node (thoracic)
[ ] Brain [ ] Lymph node (abdomen and pelvis)
[ ] Liver [ ] Lymph node (superficial, non-head and neck)
[ ] Lung [ ] Other (please describe):
[ ] Lymph node (head and neck)
Cardiac:
- FDG viability
- Coronary blood flow assessment
- Other (please describe):

Neurologic:
- Interictal seizure assessment
- Cognitive decline
- Other (please describe):

Inflammation/Infection:
Please describe:

Clinical History:
Please describe:

Specific Reason for PET-CT:
To determine if lesion is cancer:
- Pre-biopsy
- Biopsy contraindicated
- Other (please describe):

- To detect a primary tumor site in a patient with a confirmed or strongly suspected metastatic lesion
- To detect a primary tumor site in a patient with a presumed paraneoplastic syndrome
- Initial staging of histologically confirmed, newly diagnosed cancer
- Monitoring treatment response during chemotherapy
- Monitoring treatment response during radiotherapy
- Monitoring treatment response during combined therapy
- Restaging after completion of therapy
- Suspected recurrence of previously treated cancer
- Radiation therapy planning

Additional Notes:
Priority:
- Emergent
- Urgent
- Semi-urgent
- Elective

Specific date:

Known or Suspected Disease Location:
- No evidence of disease/in remission
- Localized only
- Regional involvement by direct extension, lymph node involvement, or both
- Metastatic (distant) with a single suspected site
- Metastatic (distant) with multiple suspected sites
- Unknown or uncertain

Stage:
- T
- N
- M

Stage

Current Management Strategy:
- Observation with close follow up
- Tissue biopsy (surgical, percutaneous, or endoscopic)
- Treatment

Treatment goal:
- Curative
- Palliative

Treatment types:
- Surgical
- Radiotherapy
- Chemotherapy or other biologic therapy
- Supportive
- Other

Previous Imaging:
Adult patients should have a diagnostic CT performed within the last 2-4 weeks.

- CT done at: _________________________________ Date: _________________________________
- MRI done at: _________________________________ Date: _________________________________
- Other done at: _________________________________ Date: _________________________________

Creatinine: _________________________________
GFR (preferred): _________________________________

Contrast allergy
- No
- Yes

Claustrophobic
- No
- Yes

Diabetic
- No
- IDDM
- NIDDM

Is the patient taking:
- Metformin
- C-GSF

Past medical history and relevant medications OR ☐ recent consult note attached or faxed.
Pertinent False Positives Within 3 Months:

- Biopsy
  - Surgical, date: _________________________________
  - Percutaneous, date: _________________________________
- Surgery: _________________________________ Date: _____________________
- Trauma: _________________________________ Date: _____________________
- Infection/Inflammation: _________________________________ Date: _____________________

Physician Signature: