

ONTARIO PET ACCESS PROGRAM REQUEST Paraneoplastic Neurological Syndromes (PNS)

TO BE COMPLETED BY THE REQUESTING PHYSICIAN

Referring Physician Name: _____		
Physician Phone: (_____)	ext. _____	Fax: (_____)
CPSO No: _____		
Patient Name: _____		
SURNAME	FIRST NAME	MIDDLE
OHIP Number: _____		
Telephone: (_____)		Postal Code: _____
Date of birth: ____/____/____ YYYY / MM / DD	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	

PET Centre of Choice: *(choose only one)*

<input type="checkbox"/> Thunder Bay Regional HSC	<input type="checkbox"/> Health Sciences North	<input type="checkbox"/> Ottawa Hospital
<input type="checkbox"/> Princess Margaret Hospital	<input type="checkbox"/> Sunnybrook	<input type="checkbox"/> Hospital for Sick Children
<input type="checkbox"/> McMaster University Medical Centre	<input type="checkbox"/> St. Joseph's Hamilton	<input type="checkbox"/> Windsor Regional Hospital
<input type="checkbox"/> St. Joseph's London	<input type="checkbox"/> KMH – Mississauga	<input type="checkbox"/> MyHealth - Mississauga
<input type="checkbox"/> London Health Sciences – Victoria Hospital		

Indication: PET for the evaluation of patients with suspected paraneoplastic neurologic syndromes with negative conventional imaging, with or without positive onconeural antibodies.

Section A: Initial Investigations

Is classic PNS suspected?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Are onconeural antibodies detected?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes (specify):	<input type="checkbox"/> Anti-Hu
		<input type="checkbox"/> Anti-Yo
		<input type="checkbox"/> Other, (specify): _____
Has an EEG been performed?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes (specify):	<input type="checkbox"/> Positive (specify location): _____
		<input type="checkbox"/> Negative
		<input type="checkbox"/> Equivocal (specify location): _____
Has a MRI Brain been performed?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes (specify):	<input type="checkbox"/> Positive (specify location): _____
		<input type="checkbox"/> Negative
		<input type="checkbox"/> Equivocal (specify location): _____

Fax the completed form and supporting documentation to PET Scans Ontario at (416) 217-1327. To avoid unnecessary delays in processing, please ensure that the completed forms are legible and that relevant documentation is provided. Should you have any questions about the form or the program, call the Ontario PET Access Program at 1-877-4PET-411 (1-877-473-8411).

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Section B: Completed Image Based Screening

Conventional Imaging Work-up Completed	
<input type="checkbox"/> CT:	<input type="checkbox"/> Positive (specify location): _____ <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal (specify location): _____
<input type="checkbox"/> Mammography:	<input type="checkbox"/> Positive (specify location): _____ <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal (specify location): _____
<input type="checkbox"/> Ultrasound:	<input type="checkbox"/> Positive (specify location): _____ <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal (specify location): _____
<input type="checkbox"/> Other, (specify): _____	<input type="checkbox"/> Positive (specify location): _____ <input type="checkbox"/> Negative <input type="checkbox"/> Equivocal (specify location): _____

Section C: Management Plan

Current therapy (specify): _____ _____
If the PET scan is positive for malignancy does the patient have significant comorbidities which would preclude treatment of the underlying tumour?
<input type="checkbox"/> No <input type="checkbox"/> Yes (specify): _____
Planned therapy if the PET scan is negative for malignancy (specify): _____ _____

Section D: Additional Pertinent Information

(for example, detailed management plan if imaging findings or patient management may be perceived as out of the ordinary)

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Section E: Required Supporting Documentation (**MUST** be submitted with request form)

<input type="checkbox"/> Copy of the last clinic/consult note outlining the patient's medical and treatment history; (must include a brief summary of the relevant clinical findings, investigations and treatments to date, and rationale for why paraneoplastic disorder is being considered). (from within the previous 2-3 months).

For Non-Ontario Physicians ONLY:

<input type="checkbox"/> By checking this box, I confirm that the patient named above, or relevant substitute decision-maker where applicable, consents that the patient's Personal Health Information (PHI) will be collected, used and disclosed by Ontario Health (Cancer Care Ontario) (OH-CCO) in order to determine the patient's treatment facility's eligibility to receive funding for specific cancer services and for OH-CCO to conduct health system planning. As part of evaluation of the request, it may be necessary for OH-CCO to disclose the patient's PHI to other administrative programs for health services and insured benefits at Ministry of Health.
<input type="checkbox"/> By checking this box, I certify that the information set out is true and accurate, to the best of my knowledge.

Physician Signature: _____ **Date:** _____

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