Gynecology Oncology Requisition to PET Centre TO BE COMPLETED BY THE REFERRING PHYSICIAN

Referring Physician Name:						
Physician Phone	e: <u>(</u>)	ext.	Fax: <u>(</u>)CPSO No:		
Patient Name:	SURNAME		FIRST NAME	MIDDLE		
OHIP Number: _						
Telephone: ()		Postal Code:			
Date of birth: _	YYYY	/ MM /	/	Gender: M F Other		

Fax Instructions

Fax the completed request form, (page 1 and 2), along with the required supporting documentation to the PET Centre of choice for appointment. A complete list of PET Centres and their contact information is available at PET Centre Locations List | CCO Health

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Indications: (choose of	nly one)	Patient Name	:			
STAGING CERV	/ICAL CANCER – PET for the stag	ging of patients w	ith locally advanced cervical			
Complete Sections A	B, and C					
☐ CT/MRI show ☐ CT/MRI show	Reason for PET (choose only one): CT/MRI shows positive or indeterminate pelvic nodes (>7mm, and/or suspicious morphology), OR CT/MRI shows borderline or suspicious para-aortic nodes, OR CT/MRI shows indeterminate or suspicious distant metastases (e.g., chest nodules)					
B) Histology: 🗌 Sc	uamous Cell Carcinoma 🔲 Aden	ocarcinoma 🗌	Other (specify):			
C) Clinical Stage: [□IA □IB □IIA □IIB □II	IA 🗌 IIIB 🔲 I\	/A □ IVB			
Attach the CT/MRI re	ports & provide images to the PET	Centre.				
Other information reg	arding eligibility:	-				
	YNECOLOGIC CANCER – PET fo alignancies under consideration f		f patients with recurrent e therapy (e.g., pelvic exenteration).			
Complete Sections A	B, C, and D					
☐ PET to guide	ed attempt at biopsy to establish a d					
,	Site: Endometrial Cervical nation of recurrence: Yes	☐ Vaginal ☐ No	☐ Vulvar			
-	<u> </u>	<u> </u>	(pelvic exenteration) if clinically			
D) ☐ Patient must l	nave no metastases in chest and ab	odomen (negative c	or equivocal CT chest <u>and</u> abdomen)			
Attach CT/MRI/US re	ports & provide images to the PET	Centre.				
Other information reg	arding eligibility:	-				

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Physician Signature: _____ Date: _____