Sarcoma Requisition to PET Centre
TO BE COMPLETED BY THE REFERRING PHYSICIAN

The following indications are part of the Ontario PET Registry. Completion of a post scan form is required following the PET scan. Together the pre and post scan information will provide vital data to build evidence for use of PET for this indication. Please accurately complete both the pre and post scan forms.

Referring Physician Name: _____

Physician Phone: (____) ____ ext. ____ Fax: (____) ____ CPSO No: ____

Patient Name: _____
SURNAME FIRST NAME MIDDLE

OHIP Number: _____

Telephone: (____) ____ **Postal Code:** _____

Date of birth: ____/____/____ **Gender:** ☐ M ☐ F ☐ Other
YYYY / MM / DD

Relevant Clinical History:

Please provide the most recent and relevant imaging report(s) and other relevant clinical history.

The following documents must be attached to this requisition:

☐ Relevant Imaging Studies within the previous 3 months (i.e. CT, US, MR, Other)
☐ Consult Note or Referral Letter; including relevant lab work/pathology, if relevant

Fax Instructions

Please fax the completed request form, (page 1, 2, and 3), along with the required supporting documentation to the PET Centre of choice for appointment.

	Fax no.
• Hamilton – McMaster University Medical Centre	(905) 521-2358
• Hamilton – St. Joseph's Healthcare Hamilton	(905) 308-7215
• Ottawa – Ottawa General	(613) 737-8752
• Windsor – Windsor Regional Hospital	(519) 254-4759
• London – St. Joseph's Health Care London	(519) 646-6135
• Mississauga – KMH Cardiology Centres Inc.	(905) 855-1863
• Mississauga – MyHealth Centre	(800) 416-9840
• Sudbury – Health Sciences North	(705) 671-7384
• Toronto – Princess Margaret Cancer Centre	(416) 946-2144
• Toronto – Sunnybrook Health Sciences Centre	(416) 480-5218
• Toronto – Hospital for Sick Children	(416) 813-6043
• Thunder Bay – Regional Health Sciences Centre	(807) 684-5907

Sarcoma Requisition to PET Centre

TO BE COMPLETED BY THE REFERRING PHYSICIAN

Complete sections A & B **Patient Name:**_____

Section A - Indication *(choose only one)*

☐ **DIAGNOSIS (PLEXIFORM NEUROFIBROMAS) – PET in patients with suspicion of malignant transformation of plexiform neurofibromas.**

☐ **INITIAL STAGING – PET in patients with high grade (≥ Grade 2), or ungradable, soft tissue or bone sarcomas, with negative or equivocal findings for nodal or distant metastases on conventional imaging, prior to curative intent therapy.**

Diagnosis:

☐ High grade (≥ Grade 2) **soft tissue** sarcoma ☐ Ungradable **soft tissue** sarcoma

☐ High grade (≥ Grade 2) **bone** sarcoma ☐ Ungradable **bone** sarcoma

Histology:_____

Site of disease:

Specify location: _____

N**odal metastases:**

☐ Negative ☐ Equivocal, (specify site):_____

Distant metastases:

☐ Negative

☐ Equivocal, (specify site): ☐ Lung ☐ Liver ☐ Other, (specify site):_____

☐ **RE-STAGING – PET in patients with history of treated sarcoma with suspicion of (based on conventional imaging), or histologically confirmed, recurrent sarcoma (local recurrence or limited metastatic disease) being considered for curative intent or salvage therapy**

Choose 1:

☐ Local Recurrence (specify location):_____

☐ Suspected ☐ Histologically Confirmed (specify histology):_____

☐ Limited Metastases (specify location): ☐ Lung ☐ Liver ☐ Other, (specify site):_____

☐ Suspected ☐ Histologically Confirmed (specify histology):_____

Sarcoma Requisition to PET Centre

TO BE COMPLETED BY THE REFERRING PHYSICIAN

Complete sections A & B **Patient Name:**_____

Section B – Select Management Plan

If you did not have access to PET, your action would be *(choose from both i and ii):*

i) Treatment Intent: ☐ Curative ☐ Palliative ☐ Observation

ii) Treatment Options (select all that apply):

- ☐ Biopsy, (indicate site):_____
- ☐ Surgery, (specify type):
  - ☐ Amputation
  - ☐ Resection of local recurrence
  - ☐ Metastasectomy (specify location):_____
  - ☐ Other (specify):_____
- ☐ Radiofrequency Ablation
- ☐ Radiation
- ☐ Systemic Therapy, (specify type):
  - ☐ Neoadjuvant
  - ☐ Adjuvant
  - ☐ Other (specify):_____
- ☐ Other (specify):_____

Physician Signature:_____ **Date:** _____