

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

Indications: *(choose only one)*

Patient Name: _____

SOLITARY PULMONARY NODULE (SPN) – PET for undiagnosed solid or semi-solid SPN due to:

(choose 1)

- Failed Fine Needle Aspiration (FNA) or other biopsy attempt, **OR**
- Medical condition(s) preclude(s) invasive intervention to establish diagnosis, **OR**
- SPN inaccessible to FNA

Note: PET is not indicated for the workup of pure ground glass nodules due to very low yield.

Attach CT report and provide images to the PET Centre.

Other information regarding eligibility: _____

NON-SMALL CELL LUNG CANCER (NSCLC) – PET for initial staging of patients with NSCLC being considered for potentially curative therapy; OR for re-staging of patients with locoregional recurrence, after primary treatment, being considered for definitive salvage therapy

Complete Sections A, B, and C

- A) Reason for PET *(choose one)*: Baseline Staging (new diagnosis) Re-staging (locoregional recurrence)
- B) Clinical Stage: I II IIIA IIIB
- C) Histological confirmation of NSCLC **OR**
 Strong clinical and radiological suspicion of NSCLC (e.g., based on patient history and/or imaging)

Attach CT report and provide images to the PET Centre.

Other information regarding eligibility: _____

SMALL CELL LUNG CANCER (SCLC) – PET for initial staging of patients with limited disease SCLC where combined modality therapy with chemotherapy and radiotherapy is being considered.

Clinical Stage: I II IIIA IIIB

Attach CT report and provide images to the PET Centre.

Other information regarding eligibility: _____

MESOTHELIOMA – PET for staging of patients with mesothelioma

The patient must have:

- Histologic confirmation of malignant mesothelioma
- No distant metastases on pre-PET staging
- Patient has no significant comorbidities that would preclude radical intent therapy, if clinically indicated

Attach the relevant diagnostic imaging reports and provide images to the PET Centre.

Other information regarding eligibility: _____

Physician Signature: _____ **Date:** _____