

Melanoma 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: _____ / _____ / _____ YYYY / MM / DD	Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other

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, 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	(888) 761-9156
• 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

Complete EITHER Section A or B (not both)

Section A – PET for the staging of patients with localized “high risk” melanoma, or for the evaluation of patients with isolated melanoma metastases, when surgery or other ablative therapies are being considered.

Indication (choose only one)

- Staging of localized high risk melanoma
(e.g., lymph node metastases, satellitosis or intransit metastases, or deep head & neck melanoma)
- Evaluation of isolated metastases

Attach the relevant diagnostic imaging reports (CT, US, MRI) & provide images to PET centre.

Physician Signature: _____ Date: _____

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Complete EITHER Section A or B (not both)

Patient Name: _____

Section B – PET in Immunotherapy for Metastatic Melanoma

Melanoma Demographics

Type of Melanoma: Cutaneous Mucosal Acral Lentiginous Uveal Unknown Primary
BRAF Status: Wild Type Mutant Other molecular change (specify): _____
Current line of Immunotherapy: First Line Second Line Other (specify): _____
Has the patient received prior adjuvant immunotherapy? Yes No

Indication (choose only one)

Baseline Staging – PET for the staging of patients prior to starting immunotherapy

Response Assessment – PET for response assessment of patients with metastatic melanoma currently receiving immunotherapy.

Reason for PET: Early Response Assessment (choose one): After 2 cycles After 3 cycles After 4 cycles

End of Therapy Response Assessment (specify reason):

Therapy Complete Adverse Event Patient Decision

Radiographic Complete Response or Good Partial Response

Other (specify): _____

Immunotherapy Start Date: _____ Date of most recent Immunotherapy dose: _____
YYYY-MM-DD YYYY-MM-DD

Current Immunotherapy Regimen (select all that apply): Anti PD1 Monotherapy
 Anti PD1 & Anti CTLA-4 combination therapy
 Anti CTLA-4 Monotherapy
 Other (specify): _____

Baseline PET scan available for comparison? No Yes (specify date): _____
YYYY-MM-DD

Residual Lesion(s) on CT? Not Applicable (no CT available)

No

Yes (specify total number & locations): 1 2 3 ≥ 4

Location of lesions: Lung Liver Bone Adrenal Brain

Other (specify): _____

Does patient have clinical evidence of immune related adverse event(s)?

No

Yes (select all that apply): Enterocolitis Fatigue Hematological Hepatitis Hypophysitis

Pancreatitis Rash Pneumonitis Peripheral neuropathy

Sarcoidosis Thyroiditis Other (specify): _____

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Complete EITHER Section A or B (not both)

Patient Name: _____

Section B (continued) – PET in Immunotherapy for Metastatic Melanoma

Select Management Plan – if PET were NOT available, what is your Current Management Plan

Pre-PET Treatment Plan (select all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Start Immunotherapy (specify): | <input type="checkbox"/> Anti PD1 Monotherapy |
| | <input type="checkbox"/> Anti PD1 & Anti CTLA-4 combination therapy |
| | <input type="checkbox"/> Anti CTLA-4 Monotherapy |
| | <input type="checkbox"/> Other (specify): _____ |
| <input type="checkbox"/> Continue Immunotherapy | |
| <input type="checkbox"/> Discontinue Immunotherapy | |
| <input type="checkbox"/> Surgery | |
| <input type="checkbox"/> Targeted Therapy | |
| <input type="checkbox"/> Clinical Trial, (specify the protocol or SOC Name or Number): _____ | |
| <input type="checkbox"/> Radiation | |
| <input type="checkbox"/> Chemotherapy, (specify both regimen & number of cycles): | a. Regimen _____ |
| | b. Number of Cycles: _____ |
| <input type="checkbox"/> Other, please describe _____ | |

Physician Signature: _____ Date: _____