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: _____/_____/_____ **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, 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

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

- ☐ Start Immunotherapy (specify):
  - ☐ Anti PD1 Monotherapy
  - ☐ Anti PD1 & Anti CTLA-4 combination therapy
  - ☐ Anti CTLA-4 Monotherapy
  - ☐ Other (specify):_____
- ☐ Continue Immunotherapy
- ☐ Discontinue Immunotherapy
- ☐ Surgery
- ☐ Targeted Therapy
- ☐ Clinical Trial, (specify the protocol or SOC Name or Number):_____
- ☐ Radiation
- ☐ Chemotherapy, (specify both regimen & number of cycles): a. Regimen_____
  b. Number of Cycles:_____
- ☐ Other, please describe _____

Physician Signature:_____ **Date:** _____