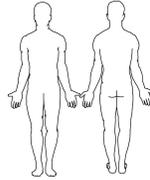


**REQUEST FOR EXAMINATION – MISSISSAUGA PET/CT**

**PATIENT INFORMATION (AFFIX LABEL IF AVAILABLE)**

Check if Applicable:  **URGENT**

Full Name (Birth): \_\_\_\_\_  
 Preferred Full Name (If Different from Birth): \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Prov.: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Cell Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Health Card #: \_\_\_\_\_ Version: \_\_\_\_\_  
 Gender: \_\_\_\_\_ Preferred Gender (If Different from Birth): \_\_\_\_\_  
 Height (cm): \_\_\_\_\_ Weight (kg): \_\_\_\_\_  
 Allergies: \_\_\_\_\_  
**Diabetic:**  Yes  No If yes, list meds: \_\_\_\_\_  
**Claustrophobia:**  Yes  No  
 Special Precautions: \_\_\_\_\_  
 Next Consultation Date: \_\_\_\_\_  
 Last Treatment Date: \_\_\_\_\_ Next Treatment Date: \_\_\_\_\_  
 Reason for Referral: \_\_\_\_\_



**REFERRING HEALTHCARE PROVIDER (STAMP LABEL IF AVAILABLE)**

Referring Provider: \_\_\_\_\_ (Print Name) \_\_\_\_\_ (Signature)  
 Billing Provider #: \_\_\_\_\_ CPSO #: \_\_\_\_\_  
 Tel #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Copy To: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 Report Delivery Preference:  Fax  HRM  Other: \_\_\_\_\_

**PLEASE INCLUDE THE FOLLOWING:**

Relevant consultation letters  CT/MRI imaging reports  Pathology/Biopsy reports

**INSURED (OHIP) SERVICES**

**SOLITARY PULMONARY NODULE**

Failed biopsy attempt  Contraindication to biopsy  
 Inaccessible to FNA

**NON-SMALL CELL LUNG CANCER**

Stage:  I  II  IIIA  IIIB  
 Baseline staging (new diagnosis)  Re-staging (locoregional recurrence)  
 Staging (oligometastatic disease)

**SMALL CELL LUNG CANCER**

Stage:  I  II  IIIA  IIIB

**THYROID CANCER**

Recurrence, ↑ Thyroglobulin  
 (Patient must withhold thyroid medications for 2 weeks OR have Thyrogen IM injections at approx. 24 and 48 hours prior to the test)

**GERM CELL TUMOURS**

Recurrence  Seminoma (post treatment residual mass)

**COLORECTAL CANCER**

Post-op recurrence and ↑ CEA  
 Elevated Biomarker: Value 1: \_\_\_\_\_ Value 2: \_\_\_\_\_  
 Staging/re-staging - apparent limited metastatic (e.g. organ restricted liver or lung metastases; or limited local recurrence)

**LYMPHOMA**

Residual mass post therapy  NHL  Hodgkin's  
 Assess Response (Hodgkin's only)

# of chemo cycles:  2  3

Date of end of last chemotherapy prior to PET: \_\_\_\_\_

**ESOPHAGEAL CANCER**

Initial staging  
 Repeat PET after pre-op/neoadjuvant treatment  
 Re-staging (locoregional recurrence)

**HEAD AND NECK CANCER**

Unknown head and neck primary  
 Nasopharyngeal cancer staging

**PET REGISTRY (CCO forms required)**

**BREAST CANCER**

T2N1  
 Oligometastatic (Distant metastatic) IDC  
 **PROSTATE CANCER** - (Cohort 8)  
 - PSMA PET form and eligibility checklist required  
 **MULTIPLE MYELOMA/PLASMACYTOMA**

\*Please indicate sites of concern on the diagram above

**PET in Immunotherapy for Metastatic Melanoma OR Merkel Cell Carcinoma**

Staging  Response Assessment

**LYMPHOMA**

Interim Response Assessment for Stage I/II Non-Hodgkin Lymphoma  
 Interim Treatment Response - Hodgkin Lymphoma

**ROUTINE ONCOLOGY**

**ANAL CANAL CANCER**

Initial staging of patients with clinical stage II-IV SCC of the anal canal  
 Initial staging to clarify equivocal conventional imaging of patients with SCC of the anal canal, specify location(s) of interest for PET:  
 Ano-rectum  Lymph Nodes  
 Other (specify): \_\_\_\_\_  
 Re-staging (limited recurrence) when further ablative therapy is being considered

**CERVICAL CANCER** - Staging (CCO form required)

**RECURRENT GYNECOLOGIC CANCER** (CCO form required)

**PENILE CANCER** - Baseline staging

**PROSTATE** (PSMA – PET req form and eligibility checklist required)

Initial staging  
 Re-staging

**BLADDER CANCER** - Initial staging (CCO form required)

**SARCOMA** (Registry form required)

**MESOTHELIOMA**

**PLEXIFORM NEUROFIBROMAS**

**BREAST CANCER (IDC) (TNM stage required)**

Baseline staging  
 Repeat post therapy, prior to surgery  
 Re-staging for locoregional recurrence of IDC

**THYROID**

Anaplastic staging  
 Medullary - staging/recurrence

**HEAD & NECK**

H&N Node positive cancer - staging  
 H&N SCC - re-staging post chemotherapy

**MELANOMA**

Staging  Evaluation of isolated mets

**HISTIOCYTIC DISORDERS**

Baseline staging  
 End of therapy response assessment  
 Re-staging

**LYMPHOMA**

Hodgkin's Lymphoma - Staging  
 Aggressive Non-Hodgkin's or Indolent Lymphoma  
 Lymphoproliferative Disorders - Staging  
 Lymphoproliferative Disorders - End of Treatment Response - Residual Disease  
 Castleman Disease

**NEUROLOGY**

**AMYLOID** (Amyloid – PET req form, eligibility checklist form required)  
 Visit [WELldiagnostics.ca/Amyloid-PET](http://WELldiagnostics.ca/Amyloid-PET) or scan the QR code for Amyloid PET Requisition as well as the Mandatory Registry paperwork to process the request as required by Ontario Health



**ACCESS AND PRIVATE PAY**

**PROSTATE CANCER** – Ga 68 PSMA – Cohort 7 (PSMA – PET req form, eligibility checklist and PSMA PET Access form required)  
 **PET ACCESS** – Fax req and additional forms to 416-217-1327  
 **PRIVATE BILLING** – Indication: \_\_\_\_\_

- All our services require a scheduled appointment.
- If you need to reschedule, please provide at least 24 hours' notice to avoid a no-show fee.
- For location details, or to chat live and book your appointment online, please visit [WELldiagnostics.ca/Locations](https://www.welldiagnostics.ca/Locations).
- We will send your diagnostic report to your referring healthcare provider who will follow-up with you. We can send it to additional healthcare providers upon your request.
- This requisition form can be submitted to any licensed Ontario healthcare facility, including hospitals and Integrated Community Health Services Centres: [Health.gov.on.ca](https://www.health.gov.on.ca)

## PET/CT SCAN

- The evening before your scan, do not consume sugary drinks or foods, such as juice, soda, rice, pasta, white bread or baked goods.
- For the full day prior to your scan, choose higher protein foods, such as nuts, seeds, meat, poultry, fish, eggs, cheese, beans and vegetables.
- Discontinue vitamins, supplements and caffeine the evening before your scan. You may take your regular medications, unless they contain caffeine.
- Do not exercise for 12 hours prior to your scan and minimize your physical activity for the full day prior to your scan.
- Do not eat or drink anything other than plain water for 6 hours prior to your scan.
- Wear loose, comfortable layers of clothing that are free of metal buttons and zippers.

### SPECIAL INSTRUCTIONS FOR DIABETIC PATIENTS:

- These instructions apply to both insulin-dependent and non-insulin dependent patients.
- In order to acquire a good PET/CT scan for you, we REQUIRE your blood sugar level to be under or equal to 10.0 mmol/L (180.0 mg/dL). It is ideal to have a blood sugar level between 4.0 – 7.0 mmol/L for our test.
- DO NOT take your Insulin or diabetic medications (metformin, glyburide, glucophage, januvia, etc.) 4 hours prior to your appointment.
- DO NOT eat or drink anything 6 hours of your appointment. Drinking plain water is encouraged for your test.
- You will be requested to provide to 2 recent glucose readings when confirming your appointment.
- If you have a morning appointment, it is suggested that you fast overnight to keep your blood sugar level down the next morning.
- If you have trouble controlling your blood sugar level or have blood sugar readings typically above 10.0 mmol/L, please notify the clinic.

### Ga-68 PSMA ILLUCIX PET/CT SCAN INSTRUCTIONS:

- No dietary restrictions prior to scan.
- Drink water the morning of the exam: (2) 16 oz glasses of water 2 hours prior to the exam. Stay hydrated.
- No vigorous exercise 24 hours prior to your appointment.
- Wear comfortable clothes, with no buckles or metal.
- If you are claustrophobic, please consult with your physician and notify the PET/CT technologist upon your arrival. If you take or anticipate needing any medication, please bring the medication with you as our facility doesn't stock medications for this purpose.
- Due to radioactivity used during the exam, we discourage visitors younger than 5 years old.
- **Important Note:** This exam requires a special, time-sensitive medication ordered specifically for you. Please arrive on time as the medication may not be useable if you are late.
- Please allow 2 hours for your entire appointment.



Credit Valley Professional Building  
2300 Eglinton Avenue West, Suite G02  
Mississauga, ON L5M 2V8

T: 416-572-1725 | F: 1-800-416-9840  
E: [mississauga\\_petct@welldiagnostics.ca](mailto:mississauga_petct@welldiagnostics.ca)

#### Cardiology Services

- Blood Pressure Monitoring
- Cardiology Consultation
- Echocardiogram
- Electrocardiogram
- Exercise Stress Test
- Holter Monitoring
- Nuclear Cardiology
- Stress Echocardiogram

#### Radiology Services

- Biopsy (Thyroid)
- Bone Mineral Density
- Mammography & OBSP
- PET/CT
- Prenatal Screening
- Ultrasound
- Vascular Ultrasound
- X-ray (Walk-in Service)



Visit [WELldiagnostics.ca](https://www.welldiagnostics.ca)  
or scan this QR code to:

- ✓ Find location services, hours, and directions
- ✓ Chat live and book appointments online
- ✓ Prepare for your test in 20+ languages
- ✓ Access reqs for sleep disorders, PET/CT and more
- ✓ Access your radiology images and results
- ✓ Get the latest news and insights
- ✓ Submit inquiry forms and satisfaction surveys
- ✓ Join our team