Centre intégré universitaire de santé et de services sociaux de l'Estrie – Centre hospitalier universitaire de Sherbrooke
Québec

INSTALLATION : _____

Date of Birth (Year / Month / Day)	Medical Record No.
RAMQ number	
Birth name	First name
Address	
City / Postal Code	Phone number
Mother's Name	First Name
Father's Name	First Name

POSITRON EMISSION TOMOGRAPHY (PET) REQUISITION

DATE | Year | Month | Day |

CLINICAL PRIORITY SCALE : ☐ B : Whitin 10 days ☐ C : Whitin 28 days ☐ D : Within 90 days (3 months) ☐ Follow-up

FAX the request to 819-820-6490. The service will contact the patient to schedule the appointment.
If urgent, call 819-346-1110 ext. 11898.
Attach relevant prior imaging reports and advise the patient to bring the imaging CD.

TO BE COMPLETED

Weight : _____ ☐ lbs ☐ kg Height : _____ ☐ ft ☐ cm Diabetes : ☐ No ☐ Yes, *Specify* : ☐ Type I ☐ Type II

FDG ONCOLOGICAL STUDY

☐ **Initial assessment of proven neoplasia or post-surgery before chemotherapy and/or radiotherapy**
Specify : ☐ Curative treatment ☐ Palliative treatment

☐ **Suspicion of :** ☐ **Recurrence** ☐ **Neoplasia without histological proof (clinical, biochemical or imaging)**
Specify : ☐ High probability ☐ Low probability

☐ **Proven recurrence :** Specify : ☐ Curative treatment ☐ Palliative treatment

☐ **Post-treatment follow-up :** ☐ Symptomatic ☐ Asymptomatic ☐ Within first year ☐ More than one year

☐ Response assessment (≥3 months) : ☐ Chemotherapy ☐ Radiotherapy ☐ Surgery
Date of *last* treatment : _____ *Next* planned treatment date* : _____
*Recommanded intervals : Chemotherapy (3 weeks), radiotherapy (3 months) and surgery (4 weeks)

MYOCARDIAL STUDY

☐ FDG viability study: ➲ LVEF (Left Ventricular Ejection Fraction) : _____ %

OTHER EXAMINATIONS

☐ FDG for inflammation/infection ➲ **Call immediately if endocarditis, sepsis, or vasculitis suspected**

☐ Brain PET ➲ ☐ FDG ☐ TAU protein ☐ Amyloid | ☐ Bone study (NaF)

☐ Somatostatin receptors (e.g., : octeotate) | ☐ Estrogen receptors (e.g. : FES)

☐ PSMA receptors (prostate-specific membrane antigen)
If applicable : ➲ Latest PSA : _____ GLEASON : _____ Initial Stage : _____

☐ Radical prostatectomy ☐ Hormone therapy : ☐ Next-generation ☐ Ongoing ☐ Completed
☐ Radiotherapy : ☐ Ongoing ☐ Completed ☐ Chemotherapy : ☐ Ongoing ☐ Completed

MANDATORY CLINICAL INFORMATION (Specify: histology, spread, clinical question, etc.)

REFERRING PHYSICIAN – SERVICE POINT

Phone N.. : _____ Fax No. : _____
Service Point Name : _____
Copy to (name and license number) : _____

STAMP

Signature of Referring Physician	Printed Name	License No.	Date

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