DOTATATE PET/CT SCAN REQUISITION

Molecular Imaging and Therapy Phone: 604-707-5951 Fax: 604-877-6245

INCOMPLETE REFERRALS WILL BE RETURNED - *Mandatory fields highlighted in red*

Current Date:

Referring Physician:

Phone: **Fax:**

For MIT Department use only

Scan Date:_____ Time:_____

Indication #:_____ 1 ☐ 2 ☐

Details:_____

Routine: ☐ V-T: ☐ Other:_____

Date:_____ PET Dr. Initial:_____

PATIENT INFORMATION

Last Name: First Name: Preferred Name:

CST Cerner MRN: PHN: ☐ Out of Province ☐ Self-pay

DOB: DD MON YYYY Gender: ☐ Out Patient ☐ In Patient Location:

Home Address: City: Postal Code:

Phone: Mobile: Weight: kg Height: cm

Family Physician: Family Physician Phone:

REQUESTED EXAM DATE:

(If left blank, earliest date possible will be booked)

Priority: ☐Urgent ☐ Routine ☐Timed

Special Instructions / Notes to Scheduler:

Indication for DOTATATE PET/CT Imaging *(select one or more criteria below (1-7)):*

- ☐ 1. To identify primary tumour when clinical suspicion of NET, unable to biopsy and conventional imaging equivocal
- ☐ 2. Initial staging of NET
- ☐ 3. Re-staging when de-bulking surgery or local directed therapy is being considered
- ☐ 4. F/U conventional imaging negative/equivocal at time of clinical and/or biochemical progression and would influence management
- ☐ 5. Assessment of potential candidates for SSTR-targeted PRRT
- ☐ 6. Assessment of other SSTR-expressing tumours: including Medullary Thyroid Ca and for staging and assessment of Pheochromocytoma and Paraganglioma
- ☐ 7. Problem-solving in pts with NET/SSTR-expressing tumours when confirmation of disease extent may impact clinical management - requires case by case review

Diagnosis / Pertinent History:

If Clinical Trial requested:

Clinical Trial Name: Radiotracer: Contact: Phone:

ADDITIONAL INFORMATION

CT scan within 3 months?	Y ☐ N ☐	Possibility of pregnancy?	Y ☐ N ☐		
MRI scan within 3 months?	Y ☐ N ☐	Interpreter required?	Y ☐ N ☐	Language:	
NM scan within 3 months?	Y ☐ N ☐	Drug Allergies?	Y ☐ N ☐	Drug/Reaction:	
Previous PET or PET/CT scan?	Y ☐ N ☐	Claustrophobic?	Y ☐ N ☐		

Doctor's Signature: MSP No:

Additional Copies of Report to:

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