^{68}Ga-DOTATATE PET Requisition to PET Centre

TO BE COMPLETED BY THE REFERRING PHYSICIAN

Referring Staff Physician Name: _____

Staff Physician Phone: (____) _____ ext. _____ Fax: (____) _____ CPSO No:_____

Staff Physician email: _____

Patient Name: _____
SURNAME FIRST NAME MIDDLE

OHIP Number: _____

Telephone: (____) _____ **Postal Code:** _____

Date of birth: _____/_____/_____ **Gender:** ☐ M ☐ F ☐ Other
YYYY / MM / DD

Fax Instructions

Please fax the completed request form, (page 1 and 2), along with the required supporting documentation to the PET Centre of choice for appointment.

	Fax no.
• London – London Health Sciences Centre, Victoria Hospital	(519) 667-6734
• Ottawa – Ottawa General	(613) 737-8752
• Toronto – Princess Margaret Cancer Centre	(416) 946-2144
• Toronto – Sunnybrook Health Sciences Centre	(416) 480-5218

IMPORTANT NOTE FOR PATIENTS TREATED WITH SOMATOSTATIN: ***It is recommended that PET be scheduled just prior (e.g., 0-7 days) to the monthly dose of long-acting octreotide or if patients are switched to short acting somatostatin, the dose be deferred until after the scan.***

Complete sections A & B

Section A – NET Demographics

- **Site of Primary (or suspected Primary) Disease:** ☐ Small Bowel ☐ Pancreas ☐ Lung ☐ Unknown Primary ☐ Other (specify):_____ ☐ Medullary Thyroid Carcinoma
- **YEAR** of pathology report date: _____ ☐ N/A
  - a. **Differentiation**: ☐ Well-Differentiated ☐ Unknown
  - b. **NET Grade**: ☐ Grade I ☐ Grade 2 ☐ Grade 3 ☐ Unknown
  - c. **Ki-67 score**: _____ ☐ Unknown
  - d. **Was the pathology heterogeneous?** ☐ Yes ☐ No ☐ Unknown
- **Prior Ga-68 DOTATATE PET Performed:** ☐ Yes, date of scan: _____/_____/_____ ☐ No
  YYYY / MM / DD

Attach any relevant imaging reports (i.e., PET, CT, MR, other) and provide images to PET Centre.

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*PET Centre Use Only

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Complete sections A & B **Patient Name:** _____

Section B – Choose ONLY ONE Indication.
Please review the SPECIAL CONSIDERATIONS on page 3.

☐ **DIAGNOSIS (choose one)**

☐ PET for the evaluation of a pancreatic, small bowel or mesenteric mass with findings suggestive of a NET (e.g., hypervascular pancreatic mass, desmoplastic mesenteric mass) on conventional imaging

☐ PET for the evaluation of extra-adrenal mass (e.g., carotid body nodule), with conventional imaging and/or elevated biomarkers suggestive of a pheochromocytoma/paraganglioma (PPGL)

☐ PET for a patient with a genetic syndrome predisposing to NETs and a biochemical and/or morphological suspicion of a NET in whom PET results would measurably impact management

☐ **INITIAL STAGING (choose one)**
Note: Initial staging PET scans should be requested **within 1 year from the initial diagnosis**.

☐ PET for a histologically proven well-differentiated NET (G1-G3), including unknown primary, or pheochromocytoma/paraganglioma (PPGL)

☐ PET for a histologically proven medullary thyroid cancer being considered for curative intent therapy

☐ **RE-STAGING (choose one)**

☐ PET for a patient with progressive NETs disease and is being considered for publicly funded Peptide Receptor Radionuclide Therapy (PRRT).

Note: For PRRT consideration, a PET scan should be completed within 12 months. However, a more recent PET scan should be considered if there are concerning clinical features (e.g., de-differentiation).

☐ New baseline PET scan for patients with new metastatic disease on conventional imaging and/or clinical suspicion of de-differentiation.

☐ *PET for a patient with NETs disease when surgery (e.g., de-bulking, focal ablation, liver-directed therapy) is being considered.

☐ *PET for a patient with NETs disease where conventional imaging is negative or equivocal at the time of clinical and/or biochemical progression.

(*): These are preliminary indications and are likely to be refined. Please visit our website, https://www.CCOHealth.ca/PET/Oncology-Indications, for access to the most recent forms.

☐ PET for a patient with medullary thyroid cancer when recurrent disease is suspected on the basis of elevated and/or rising tumour markers (e.g., calcitonin), with negative or equivocal conventional imaging work-up.

Physician Signature: _____ **Date:** _____

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Special Considerations

DIAGNOSIS

- Patients with a suspicious mass in another anatomical location (e.g., lung) without elevated biochemical markers should be considered for further workup and/or biopsy before the PET. PET could be considered after a failed biopsy or if a biopsy is not feasible.

- Patients with a pancreatic tail mass suggestive of a NET should have a Tc-99m Sulpha Colloid or Red Blood Cell scan to exclude intrapancreatic accessory spleen as both can present Ga-68 DOTATATE avid.

INITIAL STAGING

- PET is not appropriate for patients with Type 1 Gastric NET, neuroendocrine carcinomas (NEC) and adenocarcinomas with NET features.

- Unless there are unique clinical and/or structural concerns, PET is not routinely appropriate for patients with Diffuse idiopathic pulmonary neuroendocrine cell hyperplasia (DIPNECH).

- PET for the initial staging of a patient with an appendiceal NET should be considered when there are positive lymph nodes, the tumour is greater than 1 cm, and/or the tumour is invading through the serosa into the mesoappendix.

- PET for the initial staging of a patient with medullary thyroid cancer should be considered when the patient has yet to have a thyroidectomy or following it when biomarkers are positive with negative or equivocal structural imaging.

ROUTINE SURVEILLANCE

- Requests for routine surveillance when there is no clinical or biochemical suspicion of recurrence or progression are not eligible.

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