

Lymphoma Requisition to PET Centre
TO BE COMPLETED BY THE REFERRING PHYSICIAN

Referring Physician Name: _____		
Physician Phone: (_____)	ext. _____	Fax: (_____)
CPSO No: _____		
Patient Name: _____		
SURNAME	FIRST NAME	MIDDLE
OHIP Number: _____		
Telephone: (_____)		Postal Code: _____
Date of birth: _____ / _____ / _____		Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other
YYYY	MM	DD

Fax Instructions

Fax the completed request form, (page 1 and 2), along with the required supporting documentation to the PET Centre of choice for appointment. A complete list of PET Centres and their contact information is available at [PET Centre Locations List | CCO Health](#)

BASELINE STAGING PET FOR LYMPHOMA (ADULTS & PEDIATRICS)

Choose only one:

Hodgkin's Lymphoma

Aggressive Non-Hodgkin's Lymphoma (specify histology): _____

Indolent Lymphoma - where extent of disease will impact patient management (e.g., focal radiotherapy)

Attach the relevant diagnostic imaging reports (CT, US, MRI); and provide images to the PET Centre.

Physician Signature: _____ **Date:** _____

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Indications: *(choose only one)*

Patient Name: _____

INTERIM RESPONSE PET FOR HODGKIN'S LYMPHOMA (ADULTS & PEDIATRICS)

Choose only one:

2 Chemotherapy Cycles completed

3 Chemotherapy Cycles completed

Date of end of last chemotherapy prior to PET: _____
YYYY-MM-DD

Attach the pre-treatment CT report; or PET scan report if available; and provide images to the PET Centre.

INTERIM RESPONSE PET for NON-HODGKIN'S LYMPHOMA (PEDIATRICS ONLY)
(<18 years old; or ≤20 years old and treated at a pediatric centre)

Specify Histology:

Aggressive Non-Hodgkin's Lymphoma (specify histology): _____

Chemotherapy to date: 2 Cycles completed >2 Cycles completed (specify no. of cycles): _____

Date of end of last chemotherapy prior to PET: _____
YYYY-MM-DD

Attach the pre-treatment CT report; or PET scan report if available; and provide images to the PET Centre.

END OF THERAPY RESPONSE ASSESSMENT PET (ADULTS & PEDIATRICS)

- **For the evaluation of residual mass(es) or lesion(s) (e.g., bone) following chemotherapy in patients with Hodgkin's or non-Hodgkin's lymphoma when further potentially curative therapy (such as radiation or stem cell transplantation) is being considered; OR**
- **To assess response to chimeric antigen receptor (CAR) T-cell therapy, ninety (90) days post transfusion**

Complete Sections A), B), and C)

A) Residual Mass(es) or Lesion(s); **OR**
 Ninety (90) days following CAR T-cell therapy

B) Hodgkin's; **OR**
 Non-Hodgkin's (specify histology): _____

C) Date of end of last therapy prior to PET: _____
YYYY-MM-DD

Attach the relevant diagnostic imaging reports for correlation with PET and provide images to the PET Centre.

Physician Signature: _____ **Date:** _____