CARDIAC FDG PET VIABILITY REQUEST
APPROVAL REQUIRED INDICATIONS - EF > 40%
CARDIOVASCULAR FDG PET SPECIAL ACCESS

Questions? CardiacFDGPET@ottawaheart.ca
613-696-7000 ext.14869

*Last Name _____ *First Name _____ Middle Initial _____

*OHIP # _____ Version _____ *Postal Code _____ *Phone# _____

*Date of Birth _____ (yyyy-mm-dd) *Sex ☐ M ☐ F ☐ Other

Preferred Language ☐ English ☐ French ☐ Other

Complete ALL sections (I, II, III, IV and physician contact) - Incomplete requests will be returned. All requests must be accompanied by required supporting documentation as noted to proceed to expert review.

Pertinent Clinical Information (please complete)

***Priority**
☐ Inpatient
☐ Outpatient-Urgent
☐ Outpatient

I. Myocardial Viability
Candidates with known ischemic LV dysfunction & Ejection Fraction (EF) >40 % for cardiac revascularization, transplant or procedures

Revascularization, transplant or procedures is **being considered**
☐ Yes ☐ No (must answer yes to proceed as insured)

EF (%) _____ (>40)

** If EF ≤ 40%, FDG PET for viability is an insured indication. Please contact your local PET centre or complete the Cardiac FDG PET Viability Insured Indications - EF ≤ 40 requisition and submit directly to your local PET centre.*

Attach the following documentation (must be obtained within the past 12 months):

EF assessment report
AND
Current clinical note outlining patient status and medical plan

*Submission of relevant, additional supporting documents are recommended in order to facilitate expert review

II. Relevant Investigations to date (check all that apply)

☐ Stress Imaging ☐ Coronary Angio ☐ Cardiac CTA ☐ Other tests, specify: _____

III. Additional Clinical Information (indicate all 'Yes' or 'No')

NYHA ☐ II ☐ III ☐ IV MI in past 30 days ☐ Yes ☐ No Previous PCI ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No Pacemaker/AICD/CRT ☐ Yes ☐ No Previous CABG ☐ Yes ☐ No

IV. Choose one PET center below and FAX completed requisition with supporting documents to 613-696-7104 for review

☐ Ottawa - University of Ottawa Heart Institute
☐ Mississauga - KMH Cardiology Centres Inc.
☐ Toronto - Princess Margaret Cancer Centre
☐ Toronto - Sunnybrook Health Sciences Centre
☐ Toronto - St. Michael's Hospital
☐ Hamilton - St. Joseph's Healthcare
☐ London - LHSC Victoria Hospital
☐ Sudbury - Health Sciences North

Physician Contact (please complete ALL sections so we may contact you if necessary)

Name (print): _____ (Last Name) _____ (First Name)

Phone: _____ (xxx)-xxx-xxxx ext. _____ **Fax:** _____ (xxx)-xxx-xxxx

Email@: _____

Date of Request: _____ (yyyy-mm-dd)

Signature: _____

SAP Office Use Only

		Reviewers	Approved
Date Received:	____ - ____ - ____		☐ Yes ☐ No
Date Authorized:	____ - ____ - ____ (yyyy-mm-dd)		☐ Yes ☐ No
Authorized by:			☐ Yes ☐ No

Review Decision: ☐ APPROVED ☐ DECLINED ☐ INCOMPLETE/INELIGIBLE

FDG ID: ____ (PET center) - ____ (number) - ____ (ID)

(ver.2026-02-28)

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