ONTARIO PET ACCESS PROGRAM REQUEST

TO BE COMPLETED BY THE REQUESTING PHYSICIAN

Ontario Health (CCO) collects, uses and discloses information on this form to determine and verify eligibility for funding; and for the purpose of analysis or compiling statistical information with respect to the management of, evaluation or monitoring of, the allocation of resources to or planning for all or part to the health system, including the delivery of services, pursuant to section 45 of the Personal Health Information Protection Act, 2004.

Referring Physician Name: _____

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

Patient Name: _____
SURNAME FIRST NAME MIDDLE

OHIP Number: _____

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

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

PET Centre of Choice: *(choose only one)*

- ☐ Thunder Bay Regional HSC
- ☐ Princess Margaret Hospital
- ☐ Kingston Health Sciences Centre
- ☐ St. Joseph's London
- ☐ Stronach Regional Cancer Centre
- ☐ London Health Sciences Centre - Victoria Hospital
- ☐ Health Sciences North
- ☐ Sunnybrook
- ☐ St. Joseph's Hamilton
- ☐ KMH – Mississauga
- ☐ Royal Victoria Hospital
- ☐ Ottawa Hospital
- ☐ Hospital for Sick Children
- ☐ Windsor Regional Hospital
- ☐ MyHealth – Mississauga
- ☐ Lakeridge Health

Indication: PET for the evaluation of patients with suspected paraneoplastic neurologic syndromes with negative conventional imaging, with or without positive onconeuronal antibodies.

Section A: Initial Investigations

Is classic PNS suspected?

☐ Yes ☐ No

Are onconeural antibodies detected?

☐ No ☐ Yes (specify): ☐ Anti-Hu
☐ Anti-Yo
☐ Other, (specify): _____

Has an EEG been performed?

☐ No ☐ Yes (specify): ☐ Positive (specify location): _____
☐ Negative
☐ Equivocal (specify location): _____

Has a MRI Brain been performed?

☐ No ☐ Yes (specify): ☐ Positive (specify location): _____
☐ Negative
☐ Equivocal (specify location): _____

Fax the completed form and required supporting documentation to PET Scans Ontario at (416) 217-1327. To avoid unnecessary delays in processing, please ensure that the completed forms are legible, and that relevant documentation is provided. Should you have any questions about the form or the program, call the Ontario PET Access Program at 1-877-4PET-411 (1-877-473-8411).

Need this information in an accessible format? 1-877-280-8538, TTY 1-800-855-0511, info@ontariohealth.ca Document disponible en français en contactant info@ontariohealth.ca

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Paraneoplastic Neurological Syndromes (PNS)

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Section B: Completed Image Based Screening

Conventional Imaging Work-up Completed

☐ CT:
- ☐ Positive (specify location): _____
- ☐ Negative
- ☐ Equivocal (specify location): _____

☐ Mammography:
- ☐ Positive (specify location): _____
- ☐ Negative
- ☐ Equivocal (specify location): _____

☐ Ultrasound:
- ☐ Positive (specify location): _____
- ☐ Negative
- ☐ Equivocal (specify location): _____

☐ Other, (specify): _____
- ☐ Positive (specify location): _____
- ☐ Negative
- ☐ Equivocal (specify location): _____

Section C: Management Plan

Current therapy (specify): _____

_____

If the PET scan is positive for malignancy does the patient have significant comorbidities which would preclude treatment of the underlying tumour?

☐ No ☐ Yes (specify): _____

Planned therapy if the PET scan is negative for malignancy (specify):

_____

Section D: Additional Pertinent Information

(for example, detailed management plan if imaging findings or patient management may be perceived as out of the ordinary)

Section E: Required Supporting Documentation (MUST be submitted with request form)

☐ Copy of the last clinic/consult note outlining the patient's medical and treatment history; **(must include a brief summary of the relevant clinical findings, investigations and treatments to date, and rationale for why paraneoplastic disorder is being considered).** (from within the previous 2-3 months).

For Non-Ontario Physicians ONLY:

☐ By checking this box, I confirm that the patient named above, or relevant substitute decision-maker where applicable, consents that the patient's Personal Health Information (PHI) will be collected, used and disclosed by Ontario Health (Cancer Care Ontario) (OH-CCO) in order to determine the patient's treatment facility's eligibility to receive funding for specific cancer services and for OH-CCO to conduct health system planning. As part of evaluation of the request, it may be necessary for OH-CCO to disclose the patient's PHI to other administrative programs for health services and insured benefits at Ministry of Health.

☐ By checking this box, I certify that the information set out is true and accurate, to the best of my knowledge.

Physician Signature: _____ **Date:** _____

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