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: _____

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

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

YYYY / MM / DD

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

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

Radiopharmaceutical:

☐ **FDG** ☐ **Ga-68 DOTATATE-*only available at the sites with (*)*** ☐ **PSMA-*only available at the sites with (+)***

Diagnosis: *(please include topography, histology, and stage if known*)

Has histology been confirmed? ☐ Yes ☐ No

If no, reason why histology not confirmed:

PET Scan Indication: *(select all that apply)*

- ☐ Initial Diagnosis
- ☐ Staging/Initial treatment planning
- ☐ Restaging
- ☐ Treatment response assessment
- ☐ Detection of Recurrence
- ☐ Other, (specify): _____

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

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.

Was this patient discussed at a Multidisciplinary Cancer Conference (MCC)? ☐ Yes ☐ No

If yes *(answer the following two questions)*:

1. **Was there PET expertise in attendance?** ☐ Yes ☐ No
2. **Was a PET scan recommended?** ☐ Yes ☐ No

What is the clinical question to be answered with PET?

What will a PET scan demonstrate that cannot be proven by other means?

How will the PET scan impact clinical management of the patient?

1. **If PET scan is positive then patient management would be…**

2. **If PET scan is negative then patient management would be…**

Both boxes must be checked. The following documentation must be attached to this application. The review will not take place without this documentation.

☐ Clinic and/or consult note outlining the patient's relevant medical and treatment history, including the problem that PET is being asked to address
(usually the most recent clinic note will suffice)

☐ Complete conventional diagnostic work-up **from the past three months**, including all imaging studies, pathology reports, bloodwork, etc. that are relevant to the application

For Non-Ontario Physicians ONLY ***(both boxes must be checked)*:**

☐ 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 (CCO) in order to determine the patient's treatment facility's eligibility to receive funding for specific PET services and for OH (CCO) to conduct health system planning. As part of the 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 the 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:** _____

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