KMH CARDIOLOGY & DIAGNOSTIC CENTRES

Website: www.kmhlabs.com
Tel: 908-855-1860 Toll-free: 1-877-KMH-LABS (564-5227) Fax: 905-855-1863

1. Please complete and fax to KMH
2. See back for completion instructions.

PATIENT NAME:_____ WEIGHT:_____ HEIGHT: _____
D.O.B (DD/MM/YY):_____ APPOINTMENT DATE: _____
DAY PHONE #:_____ HOME PHONE #: _____
THIRD PARTY PAYER: _____ CLAIM #:_____

ONCOLOGY POSITRON EMISSION TOMOGRAPHY (PET)

90. SOLITARY PULMONARY NODULE 91. NON-SMALL CELL LUNG CANCER 92. LYMPHOMA 93. COLORECTAL 94. MELANOMA	95. HEAD AND NECK 96. BREAST 97. THYROID 98. GERM CELL TUMOUR 99. OVARIAN	100. CERVIX 101. ESOPHAGEAL 102. MYELOMA 103. OTHER:_____

If available, specify most recent staging and histologic subtype: _____
If this study is being performed to evaluate the effect of chemotherapy while on treatment, please specify:
Date of most recent treatment: _____ Date of next planned treatment: _____

NOTE: Please include a copy of initial and most recent consultation notes. Refer to back of requisition for patient instructions.

PATIENT SCREENING (to be completed by the referring physician): The following items may interfere with a PET scan and some may be potentially hazardous. Please answer **Yes** or **No** to these questions.

	YES	NO
Is there any possibility of pregnancy?		
Is the patient breast feeding?		
Is the patient diabetic? (Please see instructions on back)		
If yes, specify treatment (insulin, hypoglycemic or diet): _____		
Does the patient have any implanted device or prosthesis (pacemaker, hip prosthesis etc.)?		
If yes, please specify:_____		
Has the patient had any problems with a PET scan?		
If yes, please specify:_____		
Is the patient claustrophobic?		
Does the patient have any drug allergies?		
If yes, please specify:_____		

HAS THE PATIENT HAD ANY OF THE FOLLOWING:
Surgery or invasive intervention within the last year, specify (date/site):_____
Ongoing/recent chemotherapy, specify (date):_____
Ongoing/recent radiation therapy, specify (date/site):_____
Ongoing/recent bone marrow stimulation, specify (date/type):_____
Ongoing/recent infection, specify (site/type/date):_____
Active systemic inflammatory or granulomatous disease, specify:_____

PREVIOUS DIAGNOSTIC TESTS TO DATE (FAX REPORTS)

PET/CT:_____ MRI:_____ Nuclear Medicine:_____
CT:_____ X-ray:_____ US:_____

REASON FOR TEST:

_____
_____

Send copies to: _____ Physician's Signature and Stamp:_____

KMH USE ONLY:
I attest that this screening questionnaire has been verified and that the procedure has been explained to the patient.

Technologist: _____ Protocol: _____ Review Date: _____	Print Patient Name: _____ Patient Signature: _____ Priority: SD ND Routine

KMH would appreciate your assistance in the following procedures outlined below in order to minimize delays and expedite scheduling of PET appointments.

1. **At the top of the page please clearly indicate:**
   a) If **urgent** and reason for urgency
   b) Type of **surgery/consultation** which is already booked
   c) Date of **surgery/consultation**, if already booked

2. Please provide **accurate and current patient demographic information**, especially day and home telephone numbers so we may contact the patient to book their appointment.

3. Reason for performing the test, relevant clinical information, as well as reports from relevant previous diagnostic tests and surgical interventions must accompany the requisition to ensure the correct protocol is assigned by our Nuclear Medicine Physician

4. To ensure a diagnostic examination, **the patient needs to fast for 6 hours prior to their appointment.** Drinking water is allowed and encouraged within fasting period. For afternoon appointments, patients are permitted to have a light breakfast before the 6 hour fast.

5. Recent radiation therapy can significantly affect the result and interpretation of the tumour imaging. In most cases, it is advised to wait a minimum of 3 months after radiation therapy is completed before scheduling a PET. If it is necessary to have the study performed before this interval, please specify the reason.

For patients with diabetes:

6. Hyperglycemia (blood glucose level > 10-11 mmol/L) can significantly interfere with tumour imaging and lead to a suboptimal study. **Adequate glycemic control should be achieved before referring diabetic patients for this test.**

7. Oral hypoglycemic medication (diabetic pills) should be discontinued the day of the test. Consideration will be made to schedule patients on oral hypoglycemic medication in the morning.

8. Patients can continue their routine administration of insulin with a light breakfast. (Referring physician may advise patients taking long acting insulin separately from their short acting insulin to only take short acting insulin if appropriate). **Insulin should be withheld 3 hours before the appointment** Consideration will be made to schedule patients on insulin in the early afternoon.

PATIENT INSTRUCTIONS
Please follow the following instructions for the best test results:

1. Do not eat or drink anything except for water 6 hours prior to your appointment. No chewing gum, breath mints or candy is allowed on the day of the test, before and during your appointment.
2. Drink 2-4 glasses of water before your appointment time.
3. Avoid strenuous exercise 24 hours before your appointment.
4. Wear warm, loose, comfortable clothing, preferably without metal zippers or buttons on the day of your test.
5. Bring a list of all prescription medication you are taking currently.
6. You may take all your medications (EXCEPT diabetic medications) with water on the day of the test.
7. If you are diabetic, please follow specific instructions given to you from your referring physician. It is critical that you do NOT take any insulin within 3 hours before your appointment.
8. If you are claustrophobic, we may give you a sedative. Please arrange for transportation home.