

BREAST 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: ____/____/____ YYYY MM DD		Gender: ☐ M ☐ F ☐ Other

Fax Instructions

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

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Indications: (choose only one)

Patient Name: _____

- ☐ **LOCALLY ADVANCED INVASIVE DUCTAL BREAST CANCER** – PET for the staging of patients with histologically confirmed clinical stage IIb or stage III breast cancer being considered for curative intent combined modality treatment; and/or repeat PET on completion of neoadjuvant therapy, prior to surgery (when there is clinical suspicion of progression).

Purpose of PET scan (choose 1):

- ☐ Baseline staging; **OR**
☐ Repeat PET scan on completion of neoadjuvant therapy, prior to surgery

Select clinical TNM stage (choose 1):

- ☐ Stage IIB: T2N1* ☐ Stage IIB: T3N0 ☐ Stage III

Other information regarding eligibility: _____

Attach the relevant diagnostic imaging reports; and provide images to the PET Centre.

- ☐ **RE-STAGING FOR LOCOREGIONAL RECURRENCE OF INVASIVE DUCTAL BREAST CANCER** – PET for the re-staging of patients with locoregional recurrence, after primary treatment, being considered for ablative/salvage therapy.

Attach the relevant diagnostic imaging reports; and provide images to the PET Centre.

- ☐ ***OLIGOMETASTATIC (DISTANT METASTATIC) INVASIVE DUCTAL BREAST CANCER** – PET for staging/re-staging of patients with distant oligometastatic disease (≤ 4 metastases) on conventional workup prior to radical intent/ablative therapy.

Location & Number of Metastases:

- | | | | | |
|---|----------------------------|----------------------------|----------------------------|----------------------------|
| ☐ Appendicular Skeleton (specify number): | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| ☐ Axial Skeleton (specify number): | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| ☐ Non-Regional Lymph Nodes (specify number): | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| ☐ Liver (specify number): | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| ☐ Lung (specify number): | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |
| ☐ Other (specify location and number): _____ | ☐ 1 | ☐ 2 | ☐ 3 | ☐ 4 |

Other information regarding eligibility: _____

Attach the relevant diagnostic imaging reports; and provide images to the PET Centre.

Physician Signature: _____ **Date:** _____