Epilepsy Requisition to PET Centre

TO BE COMPLETED BY THE REFERRING PHYSICIAN

Eligibility for PET for patients with medically-intractable epilepsy being assessed for epilepsy surgery

The following indication is a part of the Ontario PET Registry. Completion of a post scan form is required following the PET scan. Together the pre and post scan information will provide vital data to build evidence for use of PET for this indication. Please accurately complete both the pre and post scan forms.

Patient Demographics:

Surname: _____ First Name: _____ Middle Name: _____

Phone: (_____)_____-_____ Province: _____ Postal Code: _____

OHIP Number:_____ - _____ -_____ - ____ Date of Birth:_____
vc YYYY-MM- DD

Gender: ☐ M ☐ F ☐ Other

Referring Physician Information (MUST be affiliated with one of the Regional Centres of Excellence below):

Surname: _____ First Name: _____ Middle Name:_____

CPSO:_____ Phone: (_____)_____-_____ ext.:____ Fax: (_____)_____-_____

Email:_____
(Optional)

Referring Physician is affiliated with which Regional Centre of Excellence:

☐ Toronto Western ☐ London Health Sciences Centre (Adults)

☐ Hospital for Sick Children ☐ London Health Sciences Centre (Children's Hospital)

Relevant Clinical History:

Please provide the most recent and relevant imaging report(s) and other relevant clinical history.

The following documents must be attached to this requisition:

☐ Relevant Brain MRI report

☐ SPECT Results (if available)

☐ Relevant video-EEG and MEG report (if available)

☐ Consult Note/Referral Letter/Results of surgery conference

Fax Instructions

Please fax the completed request form, (page 1 and 2), along with the required supporting documentation to the PET Centre of choice for appointment.

	Fax no.
• Hamilton – St. Joseph's Healthcare Hamilton	(905) 308-7215
• London – London Health Sciences Centre – Victoria Hospital	(519) 667-6734
• London – St. Joseph's Health Care London	(519) 646-6135
• Ottawa – Ottawa General	(613) 737-8752
• Toronto – Toronto Western Hospital (via Princess Margaret Cancer Centre)	(416) 946-2144
• Toronto – Hospital for Sick Children	(416) 813-6043

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(Complete sections A – D) **Patient Name:**_____

Section A (select type of seizure)

- ☐ focal seizure
- ☐ infantile spasm
- ☐ secondary generalized tonic-clonic seizure
- ☐ tonic seizure
- ☐ atonic seizure
- ☐ Other: _____

Section B (select type of epilepsy)

- ☐ lesional focal epilepsy
- ☐ non-lesional focal epilepsy
- ☐ Lennox-Gastaut
- ☐ Other:_____

Section C (select suspected epileptogenic focus area)

Choose 1 suspected lobe and 1 suspected hemisphere

Suspected Lobe:

- ☐ temporal lobe
- ☐ parietal lobe
- ☐ frontal lobe
- ☐ occipital lobe
- ☐ unclear

Suspected Hemisphere:

- ☐ right hemisphere
- ☐ left hemisphere
- ☐ bilateral

Please provide reasoning why this lobe and hemisphere is the suspected epileptogenic focus area:

Section D

If you didn't have access to PET, your action would be (select all that apply):

- ☐ Placement of intracranial electrodes
- ☐ Surgery
- ☐ Neuropsychology testing
- ☐ Other (please specify, i.e., SPECT, MRI)_____

Additional Comments:

Physician Signature: _____ **Date:** _____