Multiple Myeloma/Plasmacytoma Requisition to PET Centre

TO BE COMPLETED BY THE REFERRING PHYSICIAN

The following indications are 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.

Referring Physician Name: _____

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

Patient Name: _____
SURNAME FIRST NAME MIDDLE

OHIP Number: _____

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

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

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 Imaging Studies within the previous 3 months (i.e., CT, US, MR, Other)
☐ Consult Note or Referral Letter; including relevant lab work/pathology, if relevant

Fax Instructions

Fax the completed request form, (page 1 and 2), along with the required supporting documentation to the PET Centre of choice for appointment. A complete list of PET Centres and their contact information is available at PET Centre Locations List | CCO Health

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Complete sections A & B **Patient Name:**_____

Section A - Indication *(choose only one)*

☐ **PLASMACTYOMA – PET for patients with presumed solitary plasmacytoma on conventional work-up, who are candidates for curative intent radiotherapy.**

Location of solitary/isolated plasmacytoma:

☐ Bone ☐ Extramedullary site, (specify location):_____

☐ **SMOLDERING MYELOMA – PET for workup of patients with smoldering myeloma.**

☐ **NON-SECRETORY/OLIGOSECRETORY MYELOMA/POEMS – PET for the baseline staging and/ or response assessment of patients with non-secretory or oligosecretory myeloma or POEMS.**

Diagnosis:

☐ Non-secretory Myeloma ☐ Oligosecretory ☐ POEMS

Reason for PET:

☐ Baseline Staging

☐ Response Assessment; *Date of previous PET scan _____
YYYY-MM-DD

**Please note: previous PET scan must be a minimum of 3-4 months prior to the current request*

☐ **NEWLY-DIAGNOSED SECRETORY MULTIPLE MYELOMA – PET for the workup of patients with newly-diagnosed secretory multiple myeloma.**

Date of Diagnosis: _____
YYYY-MM-DD

Conventional Diagnostic Imaging completed within the previous 3 months: ☐ Yes ☐ No

If Yes, specify imaging completed (choose all that apply):

☐ Skeletal Survey ☐ Whole Body Low Dose CT ☐ MRI ☐ Other (specify): _____

Recent Therapy: ☐ No ☐ Yes (specify): ☐ Steroids ☐ Systemic Therapy ☐ Radiotherapy

International Staging System (ISS): ☐ Stage I ☐ Stage II ☐ Stage III ☐ Pending

Cytogenetics: ☐ High risk [17p, t(4;14), t(14;16)] ☐ Standard Risk ☐ Pending

SlimCRAB features

Hypercalcemia (serum calcium >2.75 mmol/L)	☐ Yes	☐ No	☐ Unknown
Renal Failure (CrCl <40 mL/min or serum Cr >177 umol/L)	☐ Yes	☐ No	☐ Unknown
Anemia (Hb >20g/L below normal limit or less than 100 g/L)	☐ Yes	☐ No	☐ Unknown
Bone disease (one or more osteolytic lesions on x-ray, CT)	☐ Yes	☐ No	☐ Unknown
Clonal bone marrow plasma results ≥60%	☐ Yes	☐ No	☐ Unknown
Involved: uninvolved serum free light chain ratio ≥100	☐ Yes	☐ No	☐ Unknown
MRI >1 focal lesion	☐ Yes	☐ No	☐ Unknown

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Complete sections A & B **Patient Name:**_____

Section B – Select Management Plan

(if you didn't have access to a PET scan, how would you treat this patient based on the results of the current conventional work-up)

Pre-PET Treatment Plan (select all that apply):

- ☐ Radiation (specify type and dose):
  - a. ☐ Curative ☐ Palliative
  - b. Dose:_____Gy
- ☐ Systemic Therapy, (specify both regimen & number of cycles)
  - a. Regimen:_____
  - b. Number of Cycles:_____
- ☐ Kyphoplasty/Vertebroplasty
- ☐ Bisphosphonates
- ☐ Stem Cell Transplant
- ☐ Clinical Trial, (specify the protocol or SOC Name or Number):_____
- ☐ Observation
- ☐ Other, please describe _____

Physician Signature:_____ **Date:** _____