Histiocytic Disorder 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, (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

☐ **BASELINE STAGING FDG PET FOR HISTIOCYTIC DISORDERS**

Choose only one:

- ☐ Histiocytosis X/Langerhans Cell Histiocytosis (LCH)
- ☐ Erdheim-Chester Disease (ECD)

Attach the relevant diagnostic imaging reports (CT, US, MRI); and provide images to the PET Centre.

Physician Signature: _____ **Date:** _____

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

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Indications: *(choose only one)* **Patient Name:**_____

☐ **END OF THERAPY RESPONSE ASSESSMENT FDG PET**

For the evaluation of residual mass(es) or lesion(s) (e.g., bone) following therapy in patients with Histiocytic Disorders.

Complete Sections A), B), and C)

A) ☐ Residual Mass(es) or Lesion(s);

B) ☐ Histiocytosis X/Langerhans Cell Histiocytosis (LCH)

☐ Erdheim-Chester Disease (ECD)

C) Date of end of last therapy prior to PET: _____
YYYY-MM-DD

Attach the relevant diagnostic imaging reports for correlation with PET and provide images to the PET Centre.

☐ **RESTAGING FDG PET FOR HISTIOCYTIC DISORDERS- CLINICAL SUSPICION OF RELAPSE**

Choose only one:

☐ Histiocytosis X/Langerhans Cell Histiocytosis (LCH)

☐ Erdheim-Chester Disease (ECD)

Attach recent CT report; or previous PET scan report if available; and provide images to the PET Centre.

Physician Signature:_____ **Date:** _____

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