T: 514 -933-5885 F: 514-933-4646 petct@vmmed.com
2345 Guy Street, Montreal, QC, H3H 2L9

Hospital Card or Patient ID

PSMA PET/CT Requisition

PATIENT CONTACT INFORMATION

TELEPHONE ______ CELLULAR ______ EMAIL or OTHER NUMBER ______

Weight: ______ **Height:** ______ Allergies: ______ Claustrophobia: ☐ No ☐ Yes

PROSTATE CANCER HISTORY

Initial Dx date: ______ Gleason: ______ Stage: ______ HIFU/Brachy? ☐ No ☐ Yes, date: ______

Prostatectomy? ☐ No ☐ Yes, date: ______ Pelvic/salvage RTX? ☐ No ☐ Yes, date: ______

ADT? ☐ Never ☐ Currently, last given: ______ ☐ Previously, stopped date: ______

CRPC? ☐ No ☐ Yes ARAT/ARPI? ☐ No ☐ Yes Docetaxel? ☐ No ☐ Yes Cabazitaxel? ☐ No ☐ Yes

CT chest? ☐ No ☐ Yes, date & results: ______

CT abdo/pelvis? ☐ No ☐ Yes, date & results: ______

Bone scan / PET NaF? ☐ No ☐ Yes, date & results: ______

Most recent PSA: ______ date: ______ Second most recent PSA: ______ date: ______

Lowest recorded PSA: ______ date: ______ PSA doubling time: ______

Clinical indication: *(select only one)* ☐ Initial staging ☐ Biochemical recurrence ☐ PSMA therapy assessment

Prostate cancer history details and the expected impact of the PET PSMA on treatment:

______

______

______

______

______

REFERRING PHYSICIAN INFORMATION

PHYSICIAN NAME (PRINT) ______ SIGNATURE ______ LICENSE NUMBER ______ DATE ______

TELEPHONE ______ FAX ______ CC ______

Provide CT and bone scan reports and images (CD, USB key or any secured web access) if not available on Dossier Santé Québec (DSQ).

INTERNAL NUCLEAR MEDICINE USE ONLY

Appt. date/time: ______ Prior PSMA PET? ☐ Yes, date: ______ Dose ordered: ______

Notes: