

Ontario PET SCAN Access Program Request

TO BE COMPLETED BY THE REQUESTING PHYSICIAN

Referring Physician's Name: _____

Referring Physician's Telephone: _____ and Fax: _____

Provider Number: _____

Patient Name: _____

OHIP Number --- Telephone: _____

Date of birth: ____/____/____ Sex: M F
YYYY MM DD

Postal Code _ _ _ _ _

Indications for the PET Scan: _____

Is your patient a candidate for one of the current PET clinical trials or Registry study?
 Yes No

If not :

Attach a copy of the reports from all relevant imaging studies

List all relevant imaging study	1. Date of: ____/____/____ YYYY MM DD	<input type="checkbox"/> CT <input type="checkbox"/> US <input type="checkbox"/> MR
	2. Date of: ____/____/____ YYYY MM DD	<input type="checkbox"/> CT <input type="checkbox"/> US <input type="checkbox"/> MR
	3. Date of: ____/____/____ YYYY MM DD	<input type="checkbox"/> CT <input type="checkbox"/> US <input type="checkbox"/> MR
	4. Date of: ____/____/____ YYYY MM DD	<input type="checkbox"/> CT <input type="checkbox"/> US <input type="checkbox"/> MR
	5. Date of: ____/____/____ YYYY MM DD	<input type="checkbox"/> CT <input type="checkbox"/> US <input type="checkbox"/> MR

Please fax this form and any additional documents in support of a PET Scan to Provider Services Branch at (613) 536-3184.

Should you have any questions about this form or the program, please call 1-888-359-8807

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TO BE COMPLETED BY THE REQUESTING PHYSICIAN

Patient Consent

(to be completed and signed by the patient)

I, _____, consent to my physician disclosing personal health information on, and attached to this form, to the Ministry of Health and Long-Term Care relevant to the medical condition that might qualify me for a diagnostic assessment using Positron Emission Tomography (PET). In addition, I consent to the Ministry's disclosure of this information to Cancer Care Ontario. I understand that the purpose of this disclosure of my personal health information is to determine whether I can participate in a government-funded PET scan clinical trial or registry study in Ontario. If I do not qualify for one of these studies, my personal health information may be used to determine if I could qualify for a PET examination through a review process established by Cancer Care Ontario

Signature of patient

Date

Patient Consent for minor child

(to be completed and signed by parent/legal guardian of patient)

I, _____, (name of parent/guardian) am the parent/ legal guardian of _____ (name of child). I consent to the above- named physician disclosing personal health information on, and attached to this form, to the Ministry of Health and Long-Term Care relevant to the medical condition that might qualify me for a diagnostic assessment using Positron Emission Tomography (PET). In addition, I consent to the Ministry's disclosure of this information to Cancer Care Ontario. I understand that the purpose of this disclosure of _____'s personal health information is to assess and determine whether _____ can participate in a government-funded PET scan clinical trial or registry study in Ontario. If _____ does not qualify for one of these studies, his/her personal health information may be used to determine if he/she could qualify for a PET examination through a review process established by Cancer Care Ontario

Name of parent/guardian

Signature of parent/guardian or patient

Date