



**ONCOLOGY**  
**Physician Referral Form (Clinical Trial)**

Patient Name \_\_\_\_\_ Birth date \_\_\_\_\_  
 \_\_\_\_\_ dd mmm yy **Patient's PHONE #s**

HSC # \_\_\_\_\_ CR # \_\_\_\_\_ PHIN \_\_\_\_\_ Home \_\_\_\_\_

Weight \_\_\_\_\_ kg Height \_\_\_\_\_ cm Work \_\_\_\_\_

Address \_\_\_\_\_ Cell \_\_\_\_\_

Physician \_\_\_\_\_ Phone or Pager \_\_\_\_\_

**Brief history, clinical diagnosis** \_\_\_\_\_  
 \_\_\_\_\_

**1. Tumour Diagnosis**

- |                                      |  |                                   |  |
|--------------------------------------|--|-----------------------------------|--|
| <input type="checkbox"/> Bladder     | <input type="checkbox"/> Esophageal                          | <input type="checkbox"/> Lung     | <input type="checkbox"/> Primary Unknown |
| <input type="checkbox"/> Brain       | <input type="checkbox"/> Gallbladder &<br>Cholangiocarcinoma | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> Sarcoma         |
| <input type="checkbox"/> Breast      | <input type="checkbox"/> Gastric                             | <input type="checkbox"/> Melanoma | <input type="checkbox"/> Testicular      |
| <input type="checkbox"/> Cervical    | <input type="checkbox"/> Head & Neck                         | <input type="checkbox"/> Myeloma  | <input type="checkbox"/> Thyroid         |
| <input type="checkbox"/> Colorectal  |  | <input type="checkbox"/> Ovarian  |  |
| <input type="checkbox"/> Other _____ |  |                                   |  |

Primary Site: \_\_\_\_\_ Histology: \_\_\_\_\_

Previous Malignancies? \_\_\_\_\_

**2. Primary Indication:**

- |  |  |
|--|--|
| <input type="checkbox"/> Initial Staging of Proven Malignancy    | <input type="checkbox"/> Subsequent Re-Staging     |
| <input type="checkbox"/> Indeterminate solitary pulmonary nodule | <input type="checkbox"/> Assess Treatment Response |
| <input type="checkbox"/> Characterize Mass/Lesion                | <input type="checkbox"/> Other: _____              |

**3. Relevant Treatment History:**

Treatment Type	Description of Treatment (If report not attached please complete)	Completion or last treatment dd mmm yyyy
Surgery		
Biopsy/Scope		
Chemotherapy		
Radiotherapy		

**4. Previous Imaging Studies:**

**Please attach all reports**

	Date (dd/mmm/yy)	Facility
PET		
CT		
MRI		
Nuc Med		

**5. Medications:** \_\_\_\_\_

6. Can the patient manage with minimal assistance and look after personal needs?  Yes  No  
(**Karnofsky performance score 60 or more**)

Can the patient lie supine for twenty minutes?  Yes  No

7. **Diabetes:**  No  Diet only  Oral Medication  Insulin

Physician caring for diabetes \_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ (dd mmm yy)

-----NUCLEAR MEDICINE USE ONLY-----							
<input type="checkbox"/> <b>NEAR WHOLE BODY SCAN</b> <input type="checkbox"/> <b>H&amp;N &amp; NWB</b> <b>ARMS Preference:</b> <input type="checkbox"/> Up <input type="checkbox"/> Down <input type="checkbox"/> No Pref. <b>START:</b> <input type="checkbox"/> Eyes <input type="checkbox"/> Top of head <b>STOP:</b> <input type="checkbox"/> Mid-thigh <input type="checkbox"/> Other _____ <input type="checkbox"/> <b>BRAIN</b> <input type="checkbox"/> <b>WHOLE BODY (please select parameters above)</b>				<b>LASIX</b> <input type="checkbox"/> NO <input type="checkbox"/> YES <b>ORAL CONTRAST</b> <input type="checkbox"/> NO <input type="checkbox"/> YES <b>DC THYROID MEDS</b> <input type="checkbox"/> NO <input type="checkbox"/> YES ___WK			
<b>PRIORITY</b> <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3				<b>INITIALS</b> _____			
	ACTIVITY / AMOUNT		ROUTE	INJ. SITE	DATE	TIME	TECH
Telebrix 38 Oral	ml in	ml water	Oral			h	
18F - FDG		MBq	I.V.			h	
Lasix		mg	I.V.			h	
Telebrix 38 Oral	ml in	ml water	Oral			h	

**Alternative I.V access particulars:** \_\_\_\_\_