St. Paul's Hospital
479 – 1081 Burrard Street
Vancouver, BC
V6Z 1Y6
Telephone: 604-806-9986
Fax: 604-806-9927

Patient Name:_____

DOB:_____
PHN:_____
Address:_____
Phone number:_____

Patients GP:_____

Cardiac Sarcoidosis Clinic Referral Form

Referral Date: _____

Referring Doctor :_____Billing#_____

Number of pages including this one:_____

- ☐ **PET scan only** (no Cardiology Consult required) – **please include all relevant consults/tests**
- ☐ **Sarcoid Clinic Cardiologist Consultation Required** (please select from list below)
  - ☐ Known cardiac sarcoidosis for treatment and follow up
  - ☐ Pt 60 years with unexplained new onset conduction disease
  - ☐ VT unknown cause – rule out sarcoidosis
  - ☐ Heart failure symptoms:_____

    NYHA:_____
    Latest EF:_____
  - ☐ Extra cardiac Sarcoid
  - ☐ Other (pls specify)_____

Interpreter Needed? Yes No Please specify Language:_____

	DONE	NOT DONE		DONE	NOT DONE
Chest Xray			Cardiac CT		
Echocardiogram			Cardiac MRI		
Right Heart Cath Report Coronary Angiogram – Including Diagram			Consult Notes		
List of Medications			Labs		

All Cardiac Sarcoid referrals are reviewed and triaged by Dr. Mustafa Toma, patients are contacted directly with appointments. If you have any questions or concerns, please contact our clinic directly at the number listed above.

BC Cancer Agency
CARE & RESEARCH
An agency of the Provincial Health Services Authority

CARDIAC PET/CT SCAN REQUISITION

Functional Imaging Department – Vancouver Centre
Phone: (604)707-5951 Fax: (604)877-6245

Current Date: _____
Referring Physician: _____
MSC ID: _____
Phone: _____
Fax: _____

For department use only

Appointment Date: _____ *Time:* _____
Patient Notified on: _____ *Notified by:* _____
☐ 1 ☐ 2 ☐ 3 Date: _____ Name: _____

Incomplete Referrals Will Be Returned

Patient Information **Important:** Height _____ Weight _____ (kg / lb)

Name: _____
Surname First Middle
Date of Birth: D_____ M_____ Y_____ PHN: _____ Sex: Male / Female
Home Address: _____
Home Phone: ( ) _____ Work: ( ) _____ Mobile: ( ) _____
Family Physician: _____ Phone: ( ) _____
Patient mobility: ambulatory / wheelchair / stretcher

Diagnosis/Pertinent History
(include recent surgery, treatment):

Specific Indication for Cardiac PET/CT Request: *select one from the options below*

☐ Heart Block ☐ Arrhythmia ☐ LV dysfunction ☐ Extra-cardiac sarcoid with risk factors ☐ Query response to therapy

☐ Other: _____

Essential Information

			Additional Information
Has patient received the info package?	Y ☐	N ☐	
Is the patient diabetic?	Y ☐	N ☐	Type: _____
Does patient require an interpreter?	Y ☐	N ☐	Language: _____
Does patient have IV contrast allergies?	Y ☐	N ☐	_____
CT scan within 3 months?	Y ☐	N ☐	**Performed at:** _____
MRI scan within 3 months?	Y ☐	N ☐	**Performed at:** _____
Nuclear Med scan within 3 months?	Y ☐	N ☐	**Performed at:** _____
Previous PET or PET/CT scan?	Y ☐	N ☐	**Performed at:** _____

Doctor's Signature: _____ **MSP No:** _____

Additional Copies of Report to: **Dr. Mustafa Toma 64605/** _____

BC Cancer Agency - Vancouver Centre
600 West 10th Ave
Vancouver, BC V5Z 4E6
www.bccancer.bc.ca

Providence HEALTH CARE
How you want to be treated.

BC Cancer Agency
CARE & RESEARCH

Eligibility Checklist

EXCLUSION CRITERIA: ***All boxes must be checked "No" for trial eligibility***	**Yes**	**No**
1. Patient has confirmed diabetes *(patients may be eligible but a practice diet is required ahead of time to ensure stability).*	☐	☐
2. Patient is unable to comply with special pre-scan diet (high protein / low carbohydrate diet) and prolonged fasting (minimum 12 hours) protocol	☐	☐
3. Patient is pregnant	☐	☐
4. Patient is medically unstable (e.g. acute cardiac or respiratory distress, hypotensive)	☐	☐
5. Patient exceeds the safe weight limit of the PET/CT bed (204.5 kg) or will not fit through the PET/CT machine (diameter 70 cm)	☐	☐

_____

Signature of Referring Physician

Dr. Toma to complete this section and fax to 604-877-6245**

Statement of Eligibility:

This patient is ☐ eligible / ☐ not eligible for participation in the study

Signature:	Date:
Printed Name:	

NOTES: