

PATIENT NAME: _____

ADDRESS: _____

CITY: _____ PROVINCE: _____

POSTAL CODE: _____ PHONE NUMBER: (____) _____

DATE: ____/____/____
DAY / MONTH / YEAR

PATIENT'S DATE OF BIRTH: ____/____/____
DAY / MONTH / YEAR

PET EXAMINATION REQUESTED:

ONCOLOGY CARDIAC NEUROLOGY

CLINICAL INDICATIONS / PRIMARY QUESTIONS TO BE ANSWERED:

REFERRING PHYSICIAN: _____

PHONE NUMBER: (____) _____ FAX NUMBER (____) _____

EMAIL ADDRESS: _____

PHYSICIANS SIGNATURE: _____

COPY OF REPORT TO BE SENT TO

FAX THIS FORM TO: (905) 712 - 9200