

**Epilepsy Requisition to PET Centre**  
**TO BE COMPLETED BY THE REFERRING PHYSICIAN**

**Eligibility for PET for patients with medically-intractable epilepsy being assessed for epilepsy surgery**

*The following indication is a part of the Ontario PET Registry. Completion of a post scan form is required following the PET scan. Together the pre and post scan information will provide vital data to build evidence for use of PET for this indication. Please accurately complete both the pre and post scan forms.*

**Patient Demographics:**

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

OHIP Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
VC YYY-MM-DD

Gender: ☐ M ☐ F ☐ Other

**Referring Physician Information (MUST be affiliated with one of the Regional Centres of Excellence below):**

Surname: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_

CPSO: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ ext.: \_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_-\_\_\_\_

Email: \_\_\_\_\_  
(Optional)

Referring Physician is affiliated with which Regional Centre of Excellence:

- |   |  |
|---|--|
| <input type="checkbox"/> Toronto Western            | <input type="checkbox"/> London Health Sciences Centre (Adults)              |
| <input type="checkbox"/> Hospital for Sick Children | <input type="checkbox"/> London Health Sciences Centre (Children's Hospital) |

**Relevant Clinical History:**

**Please provide the most recent and relevant imaging report(s) and other relevant clinical history.**

The following documents must be attached to this requisition:

- ☐ Relevant Brain MRI report
- ☐ SPECT Results (if available)
- ☐ Relevant video-EEG and MEG report (if available)
- ☐ Consult Note/Referral Letter/Results of surgery conference

**Fax Instructions**

**Please fax the completed request form, (page 1 and 2), along with the required supporting documentation to the PET Centre of choice for appointment.**

- Hamilton – St. Joseph's Healthcare Hamilton
- London – London Health Sciences Centre – Victoria Hospital
- London – St. Joseph's Health Care London
- Ottawa – Ottawa General
- Toronto – Toronto Western Hospital (via Princess Margaret Cancer Centre)
- Toronto – Hospital for Sick Children

**Fax no.**

(905) 308-7215  
(519) 667-6734  
(519) 646-6135  
(613) 737-8752  
(416) 946-2144  
(416) 813-6043

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**Eligibility for PET for patients with medically-intractable epilepsy being assessed for epilepsy surgery**

(Complete sections A – D)

Patient Name: \_\_\_\_\_

**Section A** (select type of seizure)

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> focal seizure | <input type="checkbox"/> infantile spasm | <input type="checkbox"/> secondary generalized tonic-clonic seizure |
| <input type="checkbox"/> tonic seizure | <input type="checkbox"/> atonic seizure  | <input type="checkbox"/> Other: _____                               |

**Section B** (select type of epilepsy)

- |  |  |
|--|--|
| <input type="checkbox"/> lesional focal epilepsy | <input type="checkbox"/> non-lesional focal epilepsy |
| <input type="checkbox"/> Lennox-Gastaut          | <input type="checkbox"/> Other: _____                |

**Section C** (select suspected epileptogenic focus area)

Choose 1 suspected lobe and 1 suspected hemisphere

**Suspected Lobe:**

- |  |  |                                       |   |                                  |
|--|--|---------------------------------------|---|----------------------------------|
| <input type="checkbox"/> temporal lobe | <input type="checkbox"/> parietal lobe | <input type="checkbox"/> frontal lobe | <input type="checkbox"/> occipital lobe | <input type="checkbox"/> unclear |
|--|--|---------------------------------------|---|----------------------------------|

**Suspected Hemisphere:**

- |   |  |                                    |
|---|--|------------------------------------|
| <input type="checkbox"/> right hemisphere | <input type="checkbox"/> left hemisphere | <input type="checkbox"/> bilateral |
|---|--|------------------------------------|

**Please provide reasoning why this lobe and hemisphere is the suspected epileptogenic focus area:**

**Section D**

**If you didn't have access to PET, your action would be (select all that apply):**

- |   |   |
|---|---|
| <input type="checkbox"/> Placement of intracranial electrodes | <input type="checkbox"/> Surgery  |
| <input type="checkbox"/> Neuropsychology testing              | <input type="checkbox"/> Other (please specify, i.e., SPECT, MRI) _____ |

**Additional Comments:**

**Physician Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_