London Health Sciences Centre

Molecular Imaging and Theranostics

NEW PATIENT REFERRAL – PLUVICTO

Telephone: 1-519-685-8500 ext. 56275

Fax: 1-519-667-6734 **Email:** PLUVICTO@lhsc.on.ca

London Health Sciences Centre
Molecular Imaging & Theranostics, B2-340
800 Commissioners Road East London,
Ontario N6A 5W9

All below information is MANDATORY. Incomplete or unsigned referrals will be returned

Please complete ALL information. Fax all related reports with this request (unless within Cerner)

PATIENT INFORMATION

Patient Name:		Sex: ☐ Male ☐ Female ☐ Other
Date of Referral (YYYY/MM/DD):		Address:
Email Address:	Alternate Contact: _____	LHSC Chart Number:
Home/Cell Phone Number: ( )	Relationship: _____	Health Insurance Number:
Business Phone Number: ( )	Phone Number: ( ) _____	Date of Birth (YYYY/MM/DD):
Patient Currently: ☐ Home ☐ Hospital Hospital Name:		Call Appointment to: ☐ Patient ☐ Physician ☐ Hospital

NOTE: this patient remains under the care of the referring physician until seen by a Molecular Imaging and Theranostics Physician

REFERRAL INFORMATION (To be completed by Referring Physician):

Referring Physician Name:	CPSO Number:
Phone Number: ( ) ext. (if applicable):	Fax Number: ( )

Referrals will only be accepted from a Medical Oncologist/Radiation Oncologist or corresponding delegate.
Referrals directly from primary providers will not be accepted.

Previous Taxane Chemotherapy: ☐ Docetaxel Number of Cycles: _____ Date of last cycle (YYYY/MM/DD): _____
☐ Cabazitaxel Number of Cycles: _____ Date of last cycle (YYYY/MM/DD): _____

Previous Hormone Therapy/Androgen Deprivation Therapy (ADT): ☐ Yes ☐ No

Abiraterone Acetate ☐ Yes ☐ No; Still on treatment or comments: _____

Previous (or ongoing) androgen receptor pathway inhibitor (ARPI) including:

Enzalutamide ☐ Yes ☐ No; Still on treatment or comments: _____

Darolutamide ☐ Yes ☐ No; Still on treatment or comments: _____

Apalutamide ☐ Yes ☐ No; Still on treatment or comments: _____

Most recent PSMA-PET scan Date:	Most recent bone scan ☐ No previous bone scan Date:

Most recent Chest/Abdomen/Pelvis CT scan Date: _____ ☐ No previous bone scan

Recent blood work attached: ☐ Yes ☐ No; Comments: _____

Clinic notes attached: ☐ Yes ☐ No; Comments: _____

Pathology report available: ☐ Yes ☐ No; Comments: _____

Date (YYYY/MM/DD): _____ **Referring Physician Signature:** _____

New Patient Referral PLUVICTO Continued

FOLLOW-UP (For Office Use Only)	
Clinic Appointment: Given to: ☐ Patient ☐ Secretary ☐ Physician ☐ Other (state) ☐ Hospital	Doctor/Service Requested: Reviewed By: _____ Physician Date Time
Appointment Cancelled By:	Reason:
Rebooked Appointment:	
Information Taken By:	Booked: