CARDIAC SARCOIDOSIS (CS) REQUEST APPROVAL REQUIRED INDICATIONS

CARDIOVASCULAR FDG PET SPECIAL ACCESS

Questions? CardiacFDGPET@ottawaheart.ca

613-696-7000 ext.14869

*Last Name _____ *First Name _____ Middle Initial _____

*OHIP # _____ Version _____ *Postal Code _____ *Phone# _____

*Date of Birth _____ (yyyy-mm-dd) *Sex ☐ M ☐ F ☐ Other

Preferred Language ☐ English ☐ French ☐ Other

Complete ALL sections (I, II, III and physician contact) - Incomplete requests will be returned. All requests must be accompanied by required supporting documentation as noted per indication to proceed to expert review.

Pertinent Clinical Information (please complete)

***Priority**

☐ Inpatient
☐ Outpatient-Urgent
☐ Outpatient

***Ketogenic diet preparation is required for all cardiac sarcoid imaging.**

I. CHOOSE ONLY ONE INDICATION (A or B or C or D)	**Attach the following supporting documentation (must be obtained within the past 12 months) Current Clinical Notes plus:**
☐ A. Patients with idiopathic sustained or non-sustained VT and/or a high PVC burden > 10%	CT OR MRI THORAX suggestive of pulmonary sarcoidosis and/or hilar or mediastinal lymphadenopathy **AND** Cardiac MRI suggestive of cardiac sarcoid.
☐ B. Patients with clinical diagnosis of nonischemic cardiomyopathy, to screen for CS as underlying etiology	CT OR MRI THORAX suggestive of pulmonary sarcoidosis and/or hilar or mediastinal lymphadenopathy **OR** Cardiac MRI suggestive of cardiac sarcoid.
☐ C. Patients with possible arrhythmogenic right ventricular cardiomyopathy, to screen for CS as possible alternative diagnosis	CT OR MRI THORAX suggestive of pulmonary sarcoidosis and/or hilar or mediastinal lymphadenopathy **AND/OR** Evidence of any degree of AV block (1st, 2nd, 3rd)
☐ D. Other: Patients who do not meet pre-approved criteria and require special access review (additional follow-up scan (>3), non-listed indications above)	Submission of revelant supporting documentation such as clinical evidence (notes), cardiac MR, CT thorax etc. required for review.

**Submission of additional, relevant supporting documents are recommended in order to facilitate expert review.*

II. INDICATE 'Yes' or 'No' TO THE FOLLOWING ADDITIONAL INFORMATION:

Diabetes ☐ Yes ☐ No Previous MI ☐ Yes ☐ No Pacemaker/AICD/CRT ☐ Yes ☐ No

III. CHOOSE ONE PET CENTER and FAX COMPLETED FORM WITH SUPPORTING DOCUMENTS to 613-696-7104 for review

☐ Ottawa - University of Ottawa Heart Institute
☐ Mississauga - KMH Cardiology Centres Inc.
☐ Toronto - Princess Margaret Cancer Centre
☐ Toronto - Sunnybrook Health Sciences Centre
☐ Toronto - St. Michael's Hospital
☐ Hamilton - St. Joseph's Healthcare
☐ London - LHSC Victoria Hospital
☐ Sudbury - Health Sciences North

Physician Contact (please complete ALL sections so we may contact you if necessary)

Name (print): _____ Last Name _____ First Name

Phone: _____ (xxx)-xxx-xxxx _____ ext. **Fax:** _____ (xxx)-xxx-xxxx

Email@: _____

Date of Request: _____ (yyyy-mm-dd)

Signature: _____

SAP Office Use Only

		Reviewers	Approved
Date Received:	____ - ____ - ____		☐ Yes ☐ No
Date Authorized:	____ - ____ - ____ (yyyy-mm-dd)		☐ Yes ☐ No
Authorized by:			☐ Yes ☐ No

Review Decision: ☐ APPROVED ☐ DECLINED ☐ INCOMPLETE/INELIGIBLE

FDG ID: ____ (PET center) - ____ (number) - ____ (ID) *(ver.2026-02-28)*

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