CARDIAC SARCOIDOSIS (CS) REQUEST
ROUTINE INDICATIONS

*Last Name _____ *First Name _____ Middle Initial _____

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

FORWARD COMPLETED REQUEST DIRECTLY TO YOUR PET CENTER

Questions? CardiacFDGPET@ottawaheart.ca
or contact your local PET center

*Sex ☐ M ☐ F ☐ Other

*Date of Birth (yyyy-mm-dd) _____

Preferred Language ☐ English ☐ French ☐ Other

Complete ALL Sections (I,II and physician contact) - Patient must meet pre-defined criteria to proceed. Supporting documentation (obtained within the past 12 months) must be available and provided upon request for routine indications. If patient does not meet pre-defined criteria, please complete the SAP Cardiac Sarcoidosis Request Approval Required form and fax to 613-696-7104 for 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)	**Required supporting documentation**
☐ A. A patient presenting with biopsy proven or a clinical diagnosis of pulmonary or systemic sarcoidosis with recent (within 12 months) MRI findings suggestive of cardiac sarcoidosis to further screen for cardiac involvement.	Cardiac MRI obtained within the past 12 months suggestive of Cardiac Sarcoidosis **AND** Current clinical consult with diagnosis suggestive of CS and/or biopsy report.
☐ B. A patient presenting at age < 70 years, with unexplained, significant high grade conduction system disease (Mobitz II 2nd or 3rd degree AV block) to screen for CS as underlying etiology.	ECG/holter demonstrating 2nd or 3rd degree AV block **AND** Current clinical consult/documented history
☐ C. To FOLLOW UP RESPONSE TO TREATMENT in a patient with a positive baseline FDG PET consistent with cardiac sarcoidosis ☐ c1 - To assess response to treatment and/or when considering a change in treatment (add or remove immunosuppressants and/or steroids; trial therapy cessation). ☐ c2 - To assess for disease relapse after a period of planned therapy cessation (previously suppressed FDG uptake required) ☐ c3 - To assess for disease relapse, after a period of therapy cessation AND new clinical deterioration (new ventricular arrythmia and/or deterioration in RV or LV function; previously suppressed FDG uptake required) ***A maximum of 3 follow-up scans may be requested following the initial diagnostic/positive FDG PET scan.***	The baseline (initial) FDG PET scan **must be positive** for CS in order to proceed with a routine follow-up scan. **AND** Current clinical consult/documented history detailing treatment and follow up status/plan **AND** Last PET scan report Which follow-up PET scan is being requested? ☐ 1st follow-up PET scan ☐ 2nd follow-up PET scan ☐ 3rd follow-up PET scan

Additional scans (> 3) must be requested via the special access review process. If the baseline scan is not positive, a request for FDG PET followup must be forwarded for expert review.

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

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

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

Name (print): _____ _____
Last Name First Name

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

Email@: _____

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

Signature: _____

Choose only one PET center to submit (fax #):

☐ Ottawa - University of Ottawa Heart Institute - (613) 696-7104
☐ Toronto - Princess Margaret Cancer Centre - (416) 946-2144
☐ Toronto - Sunnybrook Health Sciences Centre - (416) 480-5218
☐ Toronto - St. Michael's Hospital - (416) 864-5037
☐ Mississauga - KMH Cardiology Centres Inc. - (905) 855-1863
☐ Hamilton - St. Joseph's Healthcare - (905) 521-2358
☐ London - LHSC Victoria Hospital - (519) 667-6734
☐ Sudbury - Health Sciences North - (705) 671-7384

(ver. 2026-09-09)

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