INFECTIVE ENDOCARDITIS (IE) REQUEST ROUTINE INDICATIONS

FORWARD COMPLETED REQUEST DIRECTLY TO YOUR PET CENTER

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

*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 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 Infection and Inflammation Request Approval Required form and fax to 613-696-7104 for review.

Pertinent Clinical Information (please complete)

***Priority**
☐ Inpatient
☐ Outpatient-Urgent
☐ Outpatient

I. CHOOSE ONLY ONE INDICATION (A or B)

***Ketogenic diet prep is required for endocarditis imaging**

☐ **A.** Patients with **DEFINITE** diagnosis of IE, based on Duke-ISCVID criteria, to assess septic embolization.
Requirements: 2 major criteria
OR 1 major and 3 minor criteria
OR 4 minor criteria

☐ **B.** Patients with **POSSIBLE** diagnosis of IE, based on Duke-ISCVID criteria, to detect valvular/cardiac uptake (to confirm diagnosis) and septic embolization.
Requirements: 1 major and 1 minor criteria
OR 3 minor criteria

Major criteria include: **Must check all yes or no below**

i). Positive blood cultures or positive PCR for specific bacteria ☐ Yes ☐ No

ii). Echocardiography findings suggestive of IE (new vegetation, valvular perforation or aneurysm, new significant valvular regurgitation or partial dehiscence of prosthetic valve) ☐ Yes ☐ No

Minor criteria included:

i). Predisposition factors (previous history of IE, prosthetic valve, previous valve repair or CIED congenital heart disease or drug use ☐ Yes ☐ No

ii). Fever >38 C ☐ Yes ☐ No

iii). Septic emboli ☐ Yes ☐ No

iv). Blood cultures or PCR positive for bacteria other than the one in major criteria ☐ Yes ☐ No

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

Diabetes ☐ Yes ☐ No Pacemaker/AICD/CRT ☐ Yes ☐ No Valve Replacement ☐ Yes ☐ No
If yes, ☐ Tissue ☐ Mechanical

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
☐ *Ottawa - TOH General Compus *Inpatient only

(ver. 2026-09-09)

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