Northeast Radiology

X-RAY / FLUORO / CT / ULTRASOUND
CLINICAL QUESTIONNAIRE

Name: _____DOB:_____ Date: _____

Allergies: _____

1. Why has your doctor sent you for this test? Did he/she give you a specific diagnosis?

_____
_____
_____
_____

2. Is today's visit a result of an injury? YES (answer A, B & C) NO (continue to question #3)

YES A. Where did event occur? (home, park) _____
B. When did it occur? (month, day, year) _____
C. How did it occur? (events which led to injury) _____

_____
_____

3. Please describe what specific complaints/symptoms have been most bothersome to you?

_____
_____
_____

4. How long have you had these complaints/symptoms? _____

5. Did these complaints/symptoms come on suddenly or gradually? _____

6. These complaints/symptoms have:

☐ improved ☐ remained the same ☐ worsened

7. Have you had any previous surgery related to today's exam? ☐ Yes ☐ No

(If yes, type and date: _____

8. Have you had any prior tests related to today's exam?

MRI	Date: _____	Place: _____
CT Scan	Date: _____	Place: _____
Ultrasound	Date: _____	Place: _____
Nuclear Medicine	Date: _____	Place: _____

Other_____

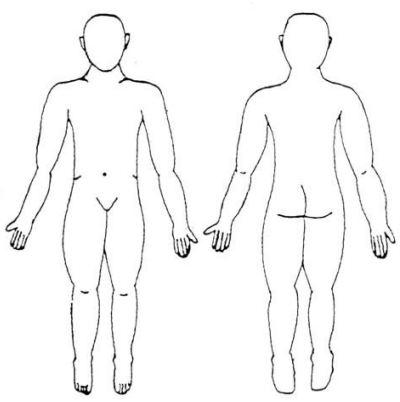
What were the results of these tests? _____

_____

(over)

PATIENT NAME: DOB:

PLEASE SHADE IN THE REGIONS THAT HURT



Female patients only:
Are you pregnant? ◯ Y / N ◯ Last menstrual period: _____

*****************STAFF USE ONLY****************

TIME OUT performed_____ AM PM Allergies Confirmed YES NO

Procedure_____Site R / L _____Tech/RN Signature_____

Radiologist_____ *****For injections only***** PAIN LEVEL: Before_____ After_____

eGFR Creatinine Reference Range - Date

Contrast/Amt mL Lot# Exp Date NDC# S / M Disc mL

Injection Site R / L Time Flow Rate IV device

Gadavist + Amt_____ mL Lot#_____Exp Date_____NDC# 7.5mL 50419-325-01 10mL 50419-325-02 S / M Disc_____mL

Lidocaine 1%/Xylocaine 1% + Amt mL Lot# Exp Date NDC# S / M Disc mL

Xylocaine 1% w/Epi **1:100,000** + Amt mL Lot# Exp Date NDC# 0409-31863-01 S / M Disc mL

Bupivacaine 0.25%/mL + Amt mL Lot# Exp Date NDC# 55150-167-10 S / M Disc mL

Bupivacaine 0.50%/mL + Amt mL Lot# Exp Date NDC# 5510-169-10 S / M Disc mL

MethylPREDNISolone 80mg/mL + Amt mL Lot# Exp Date NDC# 0703-0051-04 S / M Disc mL

Sodium Chloride 0.9% + Amt mL Lot# Exp Date NDC# 30mL - 0409-1966-02 50mL - 0409-4888-06 S / M Disc mL

Priors: NO YES

Tech/RN notes?

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STICKER

CONTRAST MATERIAL QUESTIONNAIRE

NAME: _____ DOB: _____ DATE: _____

ALLERGIES _____

_

1) Have you ever had an intravenous contrast material (X-ray dye) injection?
☐ Yes ☐ No

If yes, have you had any abnormal reactions? _____
_____

If you had an abnormal reaction, did you require treatment? ☐ Yes ☐ No

If you required treatment, what did you receive? _____
_____

2) Do you have any of the following conditions:

☐ Allergies
☐ Hay Fever
☐ Asthma
☐ Emphysema
☐ Lung Disease
☐ Diabetes
☐ Multiple Myeloma
☐ Pheochromocytoma
☐ Cancer
☐ Pregnancy
☐ Heart Disease
☐ High Blood Pressure
☐ Bleeding/Clotting problems
☐ Kidney Disease
☐ Sickle Cell Disease
☐ Food/Drug Allergies (_____)
☐ Shortness of Breath
Other (_____
_____)

Are you taking oral medication for Diabetes (Glucophage, Glucovace, Actos Plus, Metformin, etc.?) Yes ☐ No ☐ If yes, date and time of last dose_____.
(Reminder for Patient- DO NOT resume taking your Metformin based medication until you have contacted your healthcare provider for instructions)

Are you taking Interleukin II for chemotherapy? ○Yes ◉ No
Do you have a history of breast cancer with lymph nodes removed? ○Yes ○ No
Do you have a history of arterio-venous (AV) fistula? ○Yes ○ No

PLEASE TURN PAGE OVER AND COMPLETE THE SIGNATURE LINE

ACKNOWLEDGEMENT FOR INTRAVENOUS CONTRAST MEDIA

You have been scheduled to have a radiology examination by your doctor. This test will provide information to help us better understand and treat your medical problem.

As part of this test, contrast material will be injected into a small vein in your arm, before and during the time pictures are being taken. The contrast material is used because it increases the accuracy of this test by allowing us to better see many of your organs and the diseases that affect them.

This contrast material is very safe and has been used for many years on millions of people, however, like with all medicines, there are occasional side effects. The physicians and staff of this radiology office are trained to treat these reactions if they occur.

Minor side effects such as itching or stomach upset usually requires no treatment and occurs about 1 in 100 injections (1%). Serious reactions such as shortness of breath, irregular heartbeat, unconsciousness, convulsions or kidney failure usually requires medical treatment, and occurs about 1 in 10,000 injections ((0.01%). Life threatening reactions are extremely rare and occur in about 1 in 100,000 injections (0.001%). The risk of severe reaction is similar to that of taking Penicillin.

Certain people may have a higher risk for experiencing these side effects. These include people who have had prior allergic reactions to contrast media, other drugs or food, hay fever, asthma, emphysema, heart disease, diabetes or kidney disease. If you are aware of any of these problems, please inform the technologist or radiologist performing this test.

If you have any questions, please ask the technologist or radiologist who will be happy to answer them.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION, AND I HAVE HAD MY QUESTIONS ANSWERED. I AGREE TO HAVE INTRAVENOUS CONTRAST MEDIA.

_____	_____
Witness (Signature)	(Patient Signature)
_____ _____	_____
Date Date of birth	Patient Name (PRINT)

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Current Medications List

Name: _____ **DOB**_____

Include prescriptions, over the counter, herbal and vitamins.

Name of Medication	Strength and Frequency	Condition Medication Taken For

Allergies	Reactions

_____ _____

SIGNATURE **DATE**

Please use back of the form any additional medications.

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OUT-PATIENT FALL RISK ASSESSMENT

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____ SITE NAME: _____

INTERVIEWER NAME: _____ CUSTOMER NUMBER: _____

Patient: The following questions are intended to identify patients who may be at risk of falling and to help avoid potential injury. This procedure has been implemented to ensure your safety and to enable us to provide you with the best possible patient care.

Please circle the appropriate answer to each question below. Our staff will go over these questions with you prior to your examination to address any questions or concerns you may have.

1. Have you fallen recently (within the last 3 months)?	YES	NO
2. Do you use a cane, walker or other device to help you walk?	YES	NO
3. Do you require assistance to stand up?	YES	NO
4. Have you taken any medications today for anxiety or to relax you?	YES	NO
If yes, what medication? _____ Dosage _____ Time _____		
5. Are you dizzy, lightheaded, weak in your legs or unable to see or hear clearly?	YES	NO

Team Member: If the patient, patient's family member or caregiver answers "yes" to any of the above questions, transport the patient via wheelchair to the imaging system or exam/treatment room.
All patients must be assessed for falls risk prior to transporting patients from the waiting area. The entire form must be completed signed and retained in the patient's medical record whenever a patient refuses a wheelchair.
Mobile Units Only- The top portion of this document must be completed and retained in the patient's medical record whenever a mobile units lift or roll/slide door is inoperable and the units stairs must be utilized. If any "yes" answers are provided, the patient may not utilize the mobile unit stairs and must reschedule for a time when the lift/roll/slide door is operable.

RELEASE OF LIABILITY

Notwithstanding the evaluated risk of fall and Alliance's offer/recommendation to use a wheelchair for transport to/from the imaging system or exam/treatment room, I decline the use of a wheelchair. By declining the use of wheelchair for transport to/from the imaging system or exam/treatment room, I agree, acknowledge and assume all inherent risk including but not limited to the risk of falling, personal injury, damage to personal property, or otherwise. I, on behalf of myself, heirs and/or representatives, do hereby waive and agree to release and hold harmless Alliance HealthCare Services, Inc., its officers, agents, subsidiaries and employees from any and all liability for any damage, claim or injury to myself or my property or otherwise.

PATIENT SIGNATURE: _____

WITNESS SIGNATURE: _____ TITLE: _____