Northeast Radiology

NUCLEAR MEDICINE
CLINICAL QUESTIONAIRE

Name _____ DOB:_____ Date _____

Allergies _____

1. Why has your doctor sent you for this test? If any, what is your diagnosis?
   _____
   _____
   _____

2. Please describe your complaints / symptoms
   _____
   _____
   _____

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

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

5. These complaints / symptoms have: Improved ☐ Remained the same ☐ Worsened ☐

6. Have you had any previous surgery? ○ Yes / ◉ No
   If yes, type: _____

7. Have you had any prior tests?

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

What were the results of those tests? _____
_____

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

Revised: 06/03/2020

NUCLEAR MEDICINE WORKSHEET

NAME: ____ DATE: ___________________________

TECHNOLOGIST: ____

CLINICAL HISTORY: ____

____

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SCAN: ____

RADIOPHARMACEUTICAL: ____

RP DOSE: ____

METHOD OF ADMINISTRATION: ____

SITE OF ADMINISTRATION: ____

TIME OF ADMINISTRATION: ____

INJECTION-TO-IMAGING TIME: ____

I have been informed that the material (IV or ORAL) used for this test contains radioactive material.

LMP: ___________________________

____
Patient/Parent/Guarding Signature

____
Witness

Breast Feeding? Y / N

____
Date

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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: _____