Northeast Radiology

PET/CT
CLINICAL QUESTIONNAIRE

Name: _____ Date: _____

Allergies _____

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

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

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 related to today's exam? ☐ Yes ☐ No

   (If yes, type and date: _____

7. 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? _____
_____

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

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

PET / CT PATIENT INFORMATION WORKSHEET

NAME:_____ DATE:_____

ADDRESS:_____

DOB:_____ PT ID: _____ ACCESSION#: _____

DIAGNOSIS: _____ Ordering Physician: _____

CLINICAL HISTORY: Chemo _____

Surgery _____

Rx Tx _____

Pre-Injection: 18 FDG _____ mCi Time: _____

Injection: 18 FDG _____ mCi Time: _____

Post-Injection: 18 FDG _____ mCi Time: _____

Site of Administration: _____Scan Start Time:_____

Diabetic: Y N NPO 4-6hrs: Y N Caffeine: Y N Strenuous Exercise: Y N

Infiltrate: Y N_____Sex: M F LMP:_____Breast Feeding: Y N

Height: _____ Comments:_____

Weight: _____ _____

BGL: _____ _____

Pain Level: _____ _____

PHYSICIAN ORDER CHECKED (INJECTING TECH SIGNATURE)_____

Northeast Radiology

Informed Consent

I, _____, authorize Northeast Radiology or its associate to perform a Positron Emission Tomography (P.E.T.) / Computerized Axial Tomography (C.A.T.) scan. I understand that this test will give my physician information about the metabolic and physiologic activity of my body or organs. I understand that it will be necessary to check my blood sugar level prior to the scan and that a temporary intravenous line will be started in my arm or hand vein. The procedure has been explained to me and I understand that I will be injected through this I.V. line with a radioactive isotope, 18F-FDG (fluorodeoxyglucose). 18F-FDG is a radiolabeled analog of glucose that is rapidly distributed to all organs of the body. There are no known adverse reactions or allergies associated with the injection. I have had an opportunity to review this form and to ask questions. My questions have been answered to my satisfaction. I certify that I have read the preceding information and that I understand it. My consent to this procedure is voluntarily given.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Northeast Radiology

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.

Northeast Radiology

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: _____