ALLIANCE HEALTHCARE | RADIOLOGY

Last Name ____________________________________

First Name ____________________________________

Date of Birth ___________________________

PET/CT AND NUCLEAR MEDICINE ACKNOWLEDGEMENT FOR INJECTION OF NON-IODINE RADIOPHARMACEUTICAL

Radiopharmaceutical- Your physician has referred you for a procedure requiring the injection/ ingestion/inhalation of a small amount of radioactive material which will be eliminated from your body in a matter of hours or days, depending on the radiopharmaceutical agent used.

Side effects, although rare, may include redness, swelling and/or rash.

Name of Radiopharmaceutical ______________________________

I have a history of breast cancer with lymph nodes removed	☐ Yes	☐ No
I have a history of arterio-venous (AV) fistula	☐ Yes	☐ No

The technologist has explained the procedure to me and I have had my questions answered. I agree to have the procedure with the injection of the radiopharmaceutical.

____________________________________ __________ __________

Signature of Patient **Date** **Time**

(Parent or Guardian if patient is a minor or incapacitated)

Signature of Technologist:______________________________________

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