PET/CT - Part A

Factors such as patient's weight, body shape and scan type may determine if the scan can be performed.

Last Name ______________________

First Name ______________________

Date of Birth ____________ **Date** ____________

Patient: Please complete all the information contained in this boxed section.

Patient Stated Weight: ___________lbs/kgs Height: ___________

Please list previous surgeries and their dates: ______________________________

____

When was last time you had something to eat or drink except water? ______________

Medical/Dental procedures with sedation in the past 24 hours?.............................. ❑ **Yes** ❑ **No**

**** Pregnant / Nursing** ❑ **Yes** ❑ **No** **Last Menstrual Period Date** ______________

Diabetes ❑ **Yes** ❑ **No** **If yes, date and time of last insulin: injection**________ **oral** ________

Medication for Bone Marrow Stimulation (Procrit, Epogenor, Aranesp)............................... ❑ **Yes** ❑ **No**

Any barium studies in past 72 hours ....❑ **Yes** ❑ **No**

Do you have any tattoos?.......................................❑ **Yes** ❑ **No**

History of Diarrhea in past 2-3 days..................❑ **Yes** ❑ **No**

History of Claustrophobia......................................❑ **Yes** ❑ **No**

Implanted or external medical devices ....❑ **Yes** ❑ **No** *If Yes, When* ______________

(portacath, neurostimulator, pacemaker, colostomy bag, cardiac implants, surgical clips, artificial joints, dental work, etc.)

Recent Illness, infection, or injury......................❑ **Yes** ❑ **No** *If Yes, please describe* ______________

Any Falls within past 30 days..............................❑ **Yes** ❑ **No** *Most recent fall date* ______________

Are you currently experiencing any pain?.....❑ **Yes** ❑ **No** *If Yes, Where* ______________

Patient History of Cancer - Type and Date of Diagnosis: ______________________________

____

Chemotherapy...............❑ **Yes** ❑ **No** **If Yes, When** ______________________

Radiation Therapy.......❑ **Yes** ❑ **No** **If Yes, When** ______________________

History of Smoking.....❑ **Yes** ❑ **No** **If Yes, When** ______________________

Any previous imaging study related to the reason for today's exam?....... ❑ **Yes** ❑ **No**

Type of Exam ______________ Facility ______________ Date: ______________

Signature of Patient: ______________________ Date: ________ Time: ________

(*Parent or Guardian if patient is a Minor or Incapacitated*) Relationship: ______________

****Notify radiologist - pregnant patients require informed consent.**

Glucose Level Test #1: _______ **mg/dL** **Tested by:** _______

Glucose Level Test #2: _______ **mg/dL**

Glucometer reference range: ______________ **mg/dL**

Site Acceptable BGL range for Exam: ______________

Assayed Dose: ________ **mCi**

Residual Dose: ________ **mCi**

Injected Dose: ________ **mCi** **Dose Injected by:** ________

Injection Time: ____________

Injection Site: ____________

Uptake Time: ____________

Scan Start: ____________

Scan End: ____________

CTDI: ____________ **mGy**

DLP: ____________ **mGy-cm**

Additional Imaging:

Uptake Time: ____________

Scan Start: ____________

Scan End: ____________

CTDI: ____________ **mGy**

DLP: ____________ **mGy-cm**

Insert Radiopharmaceutical Label Here

I have reviewed each response with the patient or their legal guardian, power of attorney, next of kin, etc. and <u>PERFORMED CLINICAL PAUSE #1.</u>

Technologist Signature: ______________________________ **Date:** ______________

PET/CT - Part B

Medical Record # / Accession #:____________________

Exam Ordered - PET/CT:____________________

Facility Name:____________________

Referring Physician:____________ Diagnosis:____________

Reason for Exam/Clinical Symptoms: ____________________

Last Name ____________________

First Name ____________________

Date of Birth ____________ **Date** ____________

Clinical Pause #1: ❑ **Correct Patient** ❑ **Correct Exam**
❑ **Correct Radiopharmaceutical** ________**Tech Initials**

Oral Contrast Name____________________
Amount____________________ mL
Lot # ____________________
Exp. Date ____________________
Administered By: ____________________
Title: ____________________

Patient's preferred language for discussing healthcare:
❑ English ❑ Spanish ❑ Other ____________________

Is the patient allergic to any medications or latex?
❑ Yes ❑ No If Yes, please list:

1 ____________ 4 ____________
2 ____________ 5 ____________
3 ____________ 6 ____________

List all current medication(s) and check the ones taken today:
(Include birth control and over the counter, ointments, herbals, vitamins, medication patches, etc.)

____________ ❑ ____________ ❑
____________ ❑ ____________ ❑
____________ ❑ ____________ ❑
____________ ❑ ____________ ❑

Barriers to Learning ❑ Yes ❑ No

Type:	Intervention:
❑ Language	❑ Interpreter ID#________
❑ Hearing	❑ Repeat Questions
❑ Other ____________	❑ Family/Significant Other

Did the patient self-medicate
for today's procedure? .... ❑ Yes ❑ No
If yes, do they have a driver? .... ❑ Yes ❑ No

❑ Patient unaware of current medications ❑ Patient not on any medications ❑ Medication list attached (includes name & DOB)

Attachment A054(c) must be completed for all patients receiving only Radiopharmaceutical injection.
Will the Patient receive an IV injection of Iodinated Contrast? ❑ Yes ❑ No If yes, A054(b) must be completed and signed.

Injection site evaluated? ❑ **Yes** ❑ **No** **Note appearance** ____________________

Post Injection Instructions given (applicable to all patients who receive an injection). ❑ Yes ❑ No ❑ N/A

RECEIPT OF VERBAL ORDERS, TEST RESULTS, MODIFICATIONS, OR OTHER INSTRUCTIONS**:** ❑ Yes ❑ No

Information Received: ____________________

Readback confirmed with ____________ Title ____________ Date ____________ Time ______

Technologist Signature:____________________ Date ____________ Time ______

Radiologist Signature:____________________ Date ____________ Time ______

Patient was encouraged to "Speak up" with questions or concerns. ❑ Yes ❑ No

If retail, Patient Rights & Responsibilities provided to the patient. ❑ Yes ❑ No ❑ N/A

Technologist Comments ____________________

____

____

Clinical pause #2 prior to image transfer (Correct labeling, annotation and image quality)? Tech Initials ________

Prior to release, patient was assessed and found impaired? ❑ Yes ❑ No If yes, supervising physician notified? ❑ Yes ❑ No
If patient refuses further assessment, notify supervising physician and Team Member to follow policy #5023.

Team Member Signature and Title: ____________________

PATIENT SIGNATURE BELOW ONLY AT THE COMPLETION OF EXAM.

I retrieved all of my personal belongings upon completion of exam. ❑ Yes ❑ No ❑ N/A
I give my consent to receive communication/survey via text or e-mail. ❑ Yes ❑ No ❑ N/A
(Data rates may apply depending on your mobile carrier.)
Preferred Method of Communication: ❑ Cell ❑ E-mail
Cell #: (_____)____________ **E-mail:** ____________
I have received a copy of the terms and conditions for electronic communication.
❑ Yes ❑ No ❑ N/A **Patient Signature** ____________________