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 _____

NDC # _____

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:_____