

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

Any strenuous exercise in the past 48 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 (Leading zero required if residual dose less than 1)

Injected Dose: _____ mCi Dose Injected by: _____

Injection Time: _____

Injection Site: _____ Additional Imaging: _____

Uptake Time: _____ Uptake Time: _____

Scan Start: _____ Scan Start: _____

Scan End: _____ Scan End: _____

CTDI: _____ mGy CTDI: _____ mGy

DLP: _____ mGy-cm 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 **PERFORMED CLINICAL PAUSE #1.**

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 Drug Reviewed Physician Order _____ Tech Initials _____

Oral Contrast Name _____
Amount _____ mL
Lot # _____
Exp. Date _____
Administered By: _____
Title: _____

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

Barriers to Learning Yes No
Type: _____ Intervention: _____
 Language Interpreter ID# _____
 Hearing Repeat Questions
 Other _____ Family/Significant Other

Is the patient allergic to any medications, food, or latex?
 Yes No If Yes, please list:
1 _____ 4 _____
2 _____ 5 _____
3 _____ 6 _____

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

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

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
Technologist Comments _____

II 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 electronic communications & survey invitations. Yes No N/A
(Data rates may apply depending on your mobile carrier.)
My preferred method to receive communications and survey is: Text Msg E-mail Tablet
Cell #: (____) _____ E-mail: _____
I have received a copy of the terms and conditions for electronic communication.
 Yes No N/A **Patient Signature** _____