# PET/CT Patient Screening Form - Part A

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

Patient Label or Accession Number

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

Patient Name (Last, First): _____ Date of Birth: _____

Patient Address: _____ Date of Exam: _____

City, State, Zip: _____ Patient Stated Weight: _____ lbs/kgs Height: _____

**Please list previous surgeries and their dates:** _____

_____

**Any Medical/Dental procedures requiring 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** _____

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

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

**Any barium studies in past 72 hours ..... ❑ 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** _____

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

**History of Falls within past 30 days..... ❑ Yes ❑ No Most recent fall date** _____

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

**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.**

**Clinical Pause #1:** _____ Tech Initials

**Glucose Level Test #1:** _____ **mg/dl**
**Glucose Level Test #2:** _____ **mg/dl**
**Tested by:** _____
**Glucometer reference range:** _____ **mg/dl**

**Tech Notes:** _____

_____

_____

**Assayed Dose:** _____ **mCi**
**Residual Dose:** _____ **mCi**
**Injected Dose:** _____ **mCi** **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

Medical Record # / Accession #: _____

Facility Name: _____

Exam Ordered - PET/CT: _____

Referring Physician: _____

Diagnosis: _____

**Reason for Exam/Clinical Symptoms:** _____

_____

***I have reviewed this information with the patient or their legal guardian, power of attorney, next of kin, etc. and performed clinical pause #1.***

**Technologist Signature:** _____ **Date:** _____

# PET/CT Patient Screening Form - Part B

Patient Label or Accession Number

**Patient Name (Last, First):** _____

**Date of Birth:** _____ **Date:** _____

**Did the Patient receive an IV injection of Iodinated Contrast?** ❑ Yes ❑ No If yes, attachment A054(b) must be completed and signed.

**Attachment A054(c) must be completed for all patients receiving only Radiopharmaceutical injection.**

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.)**

_____ ❑ _____ ❑

_____ ❑ _____ ❑

_____ ❑ _____ ❑

_____ ❑ _____ ❑

_____ ❑ _____ ❑

❑ Patient unaware of current medications ❑ Patient not on any medications

Oral Contrast Name _____

Amount _____ mL

Lot # _____

Exp. Date _____

Administered By: _____

Title: _____

**Barriers to Learning** ❑ Yes ❑ No

| Type: | Intervention: |
|---|---|
| ❑ Language | ❑ Interpreter Used |
| ❑ 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

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.

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

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

Tech Comments: _____

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 notified of rights and opportunity to "Speak up" with questions or concerns. | ❑ Yes | ❑ No | |
| Handoff Report given to next provider of care. Medication list provided if applicable. | ❑ Yes | ❑ No | ❑ N/A |
| If retail, Patient Rights & Responsibilities provided to the patient. | ❑ Yes | ❑ No | ❑ N/A |
| Are patient reminder calls for this site made by Team Members? | ❑ Yes | ❑ No | ❑ EMR |

If yes to the above and NOT documented in an EMR or Intergy, complete row below.

Team Member Name: _____ Date: _____ Time: _____

Summary of Phone Conversation: _____

Technologist Comments _____

Clinical pause #2 prior to image transfer. Tech Initials _____

**Team Member Signature and Title:** _____

***PATIENT SIGNATURE BELOW ONLY AT THE COMPLETION OF EXAM.***

**I did not leave any personal belongings upon completion of exam.** _____