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**

Patient's preferred language for discussing healthcare:

❑ English ❑ Spanish ❑ Other _____

Is the patient allergic to any medications, food, 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.)

_____ ❑ _____ ❑

_____ ❑ _____ ❑

_____ ❑ _____ ❑

_____ ❑ _____ ❑

Oral Contrast Name _____

Amount _____ mL

Lot # _____

Exp. Date _____

Administered By: _____

Title: _____

Barriers to Learning ❑ Yes ❑ No

Type:

❑ Language

❑ Hearing

❑ Other _____

Intervention:

❑ Interpreter ID# _____

❑ Repeat Questions

❑ 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

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 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** _____