Nuclear Medicine - 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: _____

_____

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

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

When was last time you had anything to eat or drink? _____

Last ingestion of caffeine _____

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

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

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

Do you have gallstones? .....❑ Yes ❑ No

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

(portacath, neurostimulator, pacemaker, colostomy bag, cardiac implants, 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* _____

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 cannot be scanned.**

CCK dose given: _____ug Time given: _____mins

Infusion over: _____mins GBEF: _____%

Lasix given: _____mg at _____mins Captopril: _____mg

RBC Tag Method: Ultratag or PYP (circle one)

Radiopharmaceutical Name _____

Dose Amount: ☐.☐☐☐ mCi / µCi (circle one) (Leading zero required if dose less than 1)

Dose Route: Injected, Ingested, Inhaled (circle one)

Injection Site: _____ Injected by: _____

Tech Notes: _____

_____

_____

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:** _____

Nuclear Medicine - Part B

Medical Record # / Accession #: _____

Facility Name: _____

Exam Ordered: _____

Referring Physician: _____

Diagnosis: _____

Last Name _____

First Name _____

Date of Birth _____ **Date** _____

Reason for Exam/Clinical Symptoms: _____

Clinical Pause #1: Correct patient ❑ Correct drug ❑ Correct exam ❑ Correct Positioning ❑ 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 _____

Barriers to Learning ❑ Yes ❑ No

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

List all current medication(s) and check the ones taken today:

(Include birth control and over the counter, ointments, herbals, vitamins, medication patches, etc.)

_____ ❑ _____ ❑

_____ ❑ _____ ❑

_____ ❑ _____ ❑

_____ ❑ _____ ❑

_____ ❑ _____ ❑

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 an injection.

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** _____