DIAGNOSTIC HEALTH ALASKA

Alaska's Home for Medical Imaging Since 1984

General History, Screening & Consent Form

Name: _____ **Sex:** M F **Birth Date:** _____ **Age:** _____

Height: _____ **Weight:** _____ **Physician:** _____

Procedure(s): _____

Reason you are having this exam today? (Please explain in detail):

Have you had any previous exams related to this problem? Yes No

If yes please explain: _____

List previous surgeries: _____

List current Medications: _____

_____

Females only:
Are you pregnant? Y N N/A **Last menstrual period:** _____

List any drug, food, or latex allergies: _____

*** Are you taking Metformin Hydrochloride (Glucophage, Glucovance, Avandemet, Metaglip, Fortamet)?** Yes No

*** Have you ever had a previous allergic reaction to x-ray contrast (dye)?** Yes No

If yes, explain: _____

Any personal history of:

- ☐ Yes ☐ No Headaches
- ☐ Yes ☐ No Liver Disease
- ☐ Yes ☐ No Diabetes
- ☐ Yes ☐ No Stroke
- ☐ Yes ☐ No Asthma
- ☐ Yes ☐ No Allergic Respiratory Disease
- ☐ Yes ☐ No Dizziness
- ☐ Yes ☐ No Are you breast feeding at this time?
- ☐ Yes ☐ No History of falls in the last 30 days
- ☐ Yes ☐ No Kidney Disease/Kidney Failure
- ☐ Yes ☐ No Are you on Dialysis?
- ☐ Yes ☐ No Bladder Disease
- ☐ Yes ☐ No Cancer
- ☐ Yes ☐ No Heart Disease
- ☐ Yes ☐ No Prostate Problems
- ☐ Yes ☐ No Seizure Disorder
- ☐ Yes ☐ No Multiple Myeloma
- ☐ Yes ☐ No Blood disorder/Sickle cell
- ☐ Yes ☐ No Recent diarrhea in past 2-3 days?

Any other medical problems, infections, or concerns? _____

Acknowledgement: I have answered these questions to the best of my knowledge and understand the information presented to me. I give consent to perform the procedure(s) listed above.

_____ _____

Patient/Parent/Guardian Signature **Date**

_____ _____

Technologist Signature **Date**

ALLIANCE HEALTHCARE RADIOLOGY

OUT-PATIENT FALL RISK ASSESSMENT

PATIENT NAME: _____ DATE: _____

DATE OF BIRTH: _____ SITE NAME: Diagnostic Health Alaska

INTERVIEWER NAME: _____ CUSTOMER NUMBER: _____

Patient: The following questions are intended to identify patients who may be at risk of falling and to help avoid potential injury. This procedure has been implemented to ensure your safety and to enable us to provide you with the best possible patient care.
Please circle the appropriate answer to each question below. Our staff will go over these questions with you prior to your examination to address any questions or concerns you may have.

1. Have you fallen recently (within the last 3 months)?	YES	NO
2. Do you use a cane, walker or other device to help you walk?	YES	NO
3. Do you require assistance to stand up?	YES	NO
4. Have you taken any medications today for anxiety or to relax you? If yes, what medication? _____ Dosage _____ Time _____	YES	NO
5. Are you dizzy, lightheaded, weak in your legs or unable to see or hear clearly?	YES	NO

Team Member: All patients must be assessed for falls risk prior to transporting patients from the waiting area. If the patient, patient's family member or caregiver answers "yes" to any of the above questions, transport the patient via wheelchair to the imaging system or exam/treatment room.
Retention:

- Wheelchair Refusal: When the fall risk assessment determines a patient must use a wheelchair and the patient refuses, the entire form must be completed, signed and retained in the patient's medical record.
- Mobile Units Only- If the lift or roll/slide door is inoperable and the unit's stairs must be utilized, the top portion of this document must be completed and retained in the patient's medical record. If any "yes" answers are provided, the patient may not utilize the mobile unit stairs and must reschedule for a time when the lift/roll/slide door is operable.

RELEASE OF LIABILITY

Notwithstanding the evaluated risk of fall and Alliance's offer/recommendation to use a wheelchair for transport to/from the imaging system or exam/treatment room, I decline the use of a wheelchair. By declining the use of wheelchair for transport to/from the imaging system or exam/treatment room, I agree, acknowledge and assume all inherent risk including but not limited to the risk of falling, personal injury, damage to personal property, or otherwise. I, on behalf of myself, heirs and/or representatives, do hereby waive and agree to release and hold harmless Alliance HealthCare Services, Inc., its officers, agents, subsidiaries and employees from any and all liability for any damage, claim or injury to myself or my property or otherwise.

PATIENT SIGNATURE: _____

_____ _____

WITNESS SIGNATURE: TITLE

