SPECT Part A - RETAIL

Height ____________ Weight __________ lbs/kgs

Last Name: ______________________________

First Name: ______________________________

DOB: ________________ Date: ___________

Please answer the following screening questions carefully:

Any medical/dental procedures in the past 24 hours? ☐ Yes ☐ No
List any previous surgeries and their dates: ____

____

When was the last time you had something to eat or drink except water? ______________________
Last ingestion of caffeine ____
Pregnant or Nursing? ☐Yes ☐ No LMP ________________ *(**Pregnant patients require informed consent)*
Any barium studies in the past 72 hours? ☐ Yes ☐ No
Any diarrhea in the past 2-3 days? ☐ Yes ☐ No
Do you have gallstones? ☐ Yes ☐ No
Any history of claustrophobia? ☐ Yes ☐ No
Any 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, describe ____________________
Any falls in the past 30 days? ☐ Yes ☐ No If yes, most recent fall date: ______________
Are you currently experiencing any pain? ☐ Yes ☐ No If yes, where? ____________________
Patient history of cancer? ☐ Yes ☐ No If yes, type and date of diagnosis: ______________
Immunotherapy or 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 ______________

GENERAL CONSENT/ACKNOWLEDGEMENT

I consent to the ordered exam. I understand that I have the right to refuse or stop the exam at any time and I have the right to ask questions and discuss my concerns.

I have read the screening information and answered the above questions accurately.

I authorize Alliance Healthcare Services, Inc., its subsidiaries and affiliates to bill on my behalf Medicare, or any other insurance company providing benefits to me, for services performed by Alliance and I authorize payment to be made directly to Alliance. In Medicare assigned cases, Alliance agrees to accept the Medicare "allowable charge" as the full charge.

I understand that I am responsible for the payment of any patient liability including, but not limited to, deductibles, coinsurance or non-covered charges. Self-pay/Cash pay patients are expected to pay for services at the time services are rendered unless prior payment arrangements have been made.

I have been offered a printed copy of Alliance's Notice of Privacy Practices and I acknowledge receipt of the Patient Rights and Responsibilities.

I have read and I understand, acknowledge and agree to the content of this General Consent form and have had my questions answered. I give my consent to receive electronic communications and survey invitations if applicable.

Patient Signature: ________________________________ Date: ______________ Time: __________

(Parent or Guardian if patient is a Minor or Incapacitated) Relationship: ________________________

SPECT - Part B

Last Name ______________________

First Name ______________________

DOB __________ **Date** __________

Medical Record # / Accession #: ______________________

Referring Physician: ______________________

Ordered Exam: ______________________

Facility Name: ______________________

Reason for Exam/Clinical Symptoms: ______________________

Clinical Pause #1: ☐ Correct Patient ☐ Correct Procedure ☐ Correct Drug ☐ Reviewed Referring Physician Order

Tech Initials __________

Falls risk assessment was conducted by Alliance Team Member upon first greeting the patient. TM Initials __________

Did patient pre-medicate for exam? ☐ Yes ☐ No If yes, does patient have a driver? ☐ Yes ☐ No ☐ N/A

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

Patient's preferred survey method: ☐ Text ☐ E-mail ☐ Tablet ☐ N/A- No survey

Cell number or e-mail address: ______________________

Barriers to Learning: ☐ Yes ☐ No	
Type	**Intervention**
☐ Language	☐ Interpreter ID# __________
☐ Hearing	☐ Repeat/Write Questions
☐ Other	☐ Family/Significant Other

Allergies to any medications, food, or latex? ☐ Yes ☐ No

If yes, please List:

____

____

List all current medications including all prescriptions, over the counter items, ointments, vitamins, and herbals. Attach list if available. Check the box for any medications taken today.

__________ ☐	__________ ☐	__________ ☐
__________ ☐	__________ ☐	__________ ☐
__________ ☐	__________ ☐	__________ ☐

☐ Patient unaware of current medications ☐ Patient not on any medications ☐ Medication list attached (includes name & DOB)

RECEIPT OF VERBAL ORDERS, TEST RESULTS, MODIFICATIONS, OR OTHER INSTRUCTIONS ☐ Yes ☐ No

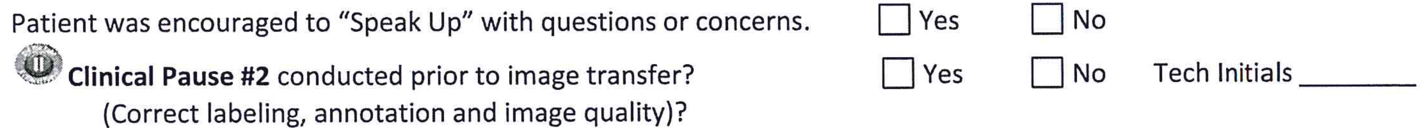
Information Received: ______________________

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



Clinical Pause #2 conducted prior to image transfer? ☐ Yes ☐ No Tech Initials __________

(Correct labeling, annotation and image quality)?

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.

Tech Comments: ______________________

____

All belongings have been returned to the patient following the exam. ☐ Yes ☐ No ☐ Inpatient-N/A

Technologist Signature: ______________________

ALLIANCE HEALTHCARE | RADIOLOGY

Last Name ______________________________

First Name ______________________________

Date of Birth ________________

SPECT: RADIOPHARMACEUTICAL ADMINISTRATION RECORD

For Technologist Use Only

History of breast cancer with lymph nodes removed? ☐ Yes ☐ No
History of an arterio-venous (AV) fistula? ☐ Yes ☐ No

CCK dose given: __________ug   Time given: __________mins

Infusion over: __________mins   GBEF: ____________%

Lasix given: ___________mg at __________mins

RBC Tag Method: Ultratag or PYP
(circle one)

Captopril: __________mg

Lexiscan: __________mg

Aminophylline: _________mg

Adenosine: ____________mg

Radiopharmaceutical Name:

____

Dose Amount: ☐☐.☐☐☐
(Leading zero required if dose is less than 1)

Insert Radiopharmaceutical Label Here

Dose Route: Injected Ingested Inhaled (circle one)

Injection Site: ______________________________

Injected by: __________________

Injection Device Used (Type and Gauge): ____

Injection site evaluated prior to patient's release? ☐ Yes ☐ No
Note appearance: ______________________________

Post Injection Instructions given ☐ Yes ☐ No

Tech Notes: ____

____

____ ____________ __________
Signature of Technologist **Date** **Time**