SPECT Part A - RETAIL

Last Name: ______________________________

First Name: ______________________________

DOB: _________________ Date: ___________

Height ____________ Weight _________ lbs/kgs

Please answer the following screening questions carefully:

Any medical/dental procedures with sedation 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 Akumin, its subsidiaries and affiliates to bill on my behalf Medicare, or any other insurance company providing benefits to me, for services performed by Akumin and I authorize payment to be made directly to Akumin. In Medicare assigned cases, Akumin 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 Akumin'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: ______________________________