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 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. Oxygen: Flow Rate________Liters/Minute Cylinder Pressure________PSI

______________ ☐ ______________ ☐ ______________ ☐
______________ ☐ ______________ ☐ ______________ ☐
______________ ☐ ______________ ☐ ______________ ☐

☐ 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: ______________________