PET/CT PATIENT SCREENING FORM - PART A

Factors such as patient's weight, body habitus and scan type may determine if the scan can be performed.

Patient: Please complete all the information contained in this boxed section.

Patient Name (Last, First): ______________________ Date of Birth: __________

Patient Address: ______________________ Date of Exam: __________

City, State, Zip: ______________________ Patient Stated Weight: ______ lbs/kgs Height: ______

Please list previous surgeries and their dates: ______________________

____

**** Pregnant / Nursing LMP Date** __________ **❑ Yes ❑ No**

Diabetes ❑ Yes ❑ No If yes, date and time of last insulin injection __________ **oral** __________

When was last time you had something to eat or drink except water? __________

Medication for Bone Marrow Stimulation (Procrit, Epogenor, Aranesp) . . . **❑ Yes ❑ No**

Any barium studies in past 7 days . . . . **❑ Yes ❑ No**

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, please describe** __________

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

History of Falls within past 30 days . . . . **❑ Yes ❑ No Most recent fall date** __________

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

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** __________

History of Smoking . . . . **❑ 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.**

Tech Notes: ______________________

____

____

Glucose Level Test #1: ______ mg/dl Glucose Level Test #2: ______ mg/dl

Tested By: __________ Tested By: __________

__________ - __________ mg/dl (Glucometer Reference Range)

Injection Time: __________ **Assayed Dose:** __________ mCi

Injection Site: __________ **Injection Dose:** __________ mCi

Uptake Time: __________

CTDI __________ mGy

DLP __________ mGy-cm

Medical Record # / Accession #: __________

Facility Name: __________

Exam Ordered - PET/CT: __________

Referring Physician/Specialty: __________

Diagnosis: __________

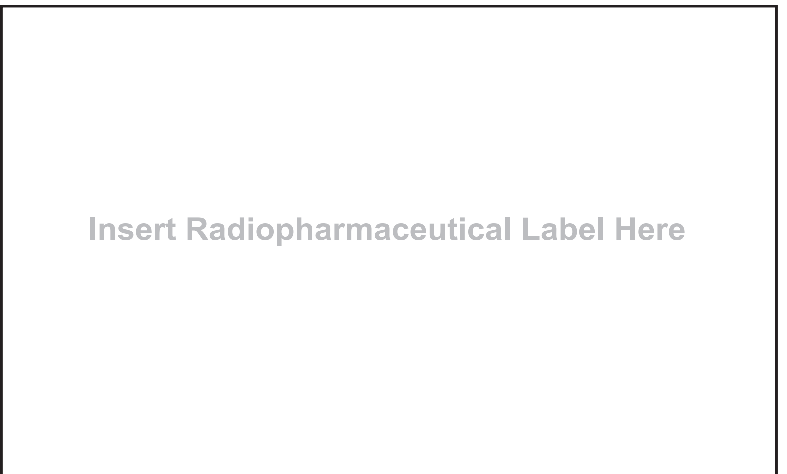
Reason for Exam/Clinical Symptoms:

____

____

____

____



I have reviewed this information with the patient or their legal guardian, power of attorney, next of kin, etc. and performed a clinical pause.

Technologist Signature: ______________________ **Date:** __________

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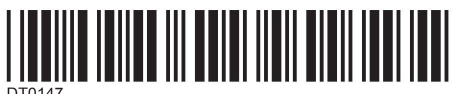
Mercy Medical Center

2700 Stewart Parkway Roseburg, OR 97471



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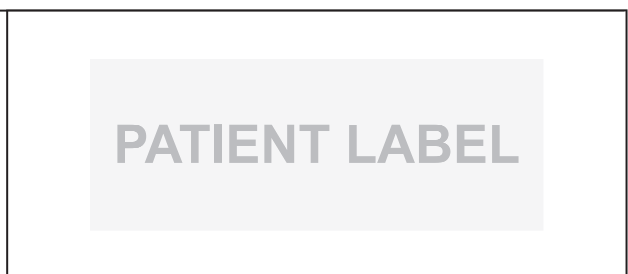

PET/CT PATIENT SCREENING FORM - PART B

Patient Name (Last, First): ________________________________ **Date of Birth:** __________________ **Date:** __________________

Did the Patient receive an IV injection of Iodinated Contrast? ❑ Yes ❑ No If yes, attachment A054(b) must be completed and signed.
Attachment A054(c) must be completed for all patients receiving only FDG injection.

Clinical pauses conducted prior to exam **AND** prior to image transfer.
Tech Initials ____________

Oral Contrast Name ______________________________
Amount ______________________________ mL
Lot # ______________________________
Exp. Date ______________________________
Administered By______________________________
Title ______________________________

Patient's preferred language for discussing healthcare:

❑ English ❑ Spanish ❑ Other ______________________________

Is the patient allergic to any medications or latex?
❑ Yes ❑ No If Yes, please list:

1 ______________________ 4 ______________________
2 ______________________ 5 ______________________
3 ______________________ 6 ______________________

Barriers to Learning ❑ Yes ❑ No

Type:	Intervention:
❑ Language	❑ Interpreter Used
❑ Hearing	❑ Repeat Questions
❑ Other ________________	❑ Family/Significant Other

List any medication(s) the patient has taken today and all current medications:
(Include birth control and over the counter, ointments, herbals, vitamins, medication patches, etc.)

1 ______________________ 6 ______________________
2 ______________________ 7 ______________________
3 ______________________ 8 ______________________
4 ______________________ 9 ______________________
5 ______________________ 10 ______________________

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

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 Alliance personnel to follow policy #5023.
Injection site evaluated? ❑ Yes ❑ No Note appearance ______________________________
Comments: ______________________________

RECEIPT OF VERBAL ORDERS, TEST RESULTS, MODIFICATIONS, OR OTHER INSTRUCTIONS: ❑ Yes ❑ No
Information Received: ______________________________
Readback confirmed with: ______________________ Title ____________ Date __________ Time __________
Technologist or Radiologist Signature: ______________________ Date __________ Time __________

Post Injection Instructions given (applicable to all patients who receive an injection).	❑ Yes	❑ No	❑ N/A
Patient notified of rights and opportunity to "Speak up" with questions or concerns	❑ Yes	❑ No	
Handoff Report given to next provider of care. Medication list provided if applicable.	❑ Yes	❑ No	❑ N/A
If retail, Patient Rights & Responsibilities provided to the patient.	❑ Yes	❑ No	❑ N/A
Are patient reminder calls for this site made by Alliance Team Members?	❑ Yes	❑ No	❑ EMR

If yes to the above and NOT documented in an EMR or Intergy, complete row below.
Team Member Name: ______________________ Date __________ Time __________
Summary: ______________________________
Technologist Comments ______________________________
____

Team Member Signature and Title: ______________________________

PATIENT SIGNATURE BELOW ONLY AT THE COMPLETION OF EXAM.

I did not leave any personal belongings upon completion of exam. ______________________________

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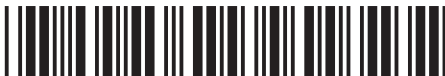

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PATIENT LABEL