Oncologic PET-CT Screening

Patient sticker

Patient name: _____

Last time of food or drink *(including gum or mints):* _____

☐ Y ☐ N **Have you ever been diagnosed with cancer, past or present?**

Which type: _____

What treatment: _____

☐ Y ☐ N **List <u>any</u> surgeries or <u>recent</u> infections?**

If yes, location/date: _____

☐ Y ☐ N **Are you diabetic?**

If yes, please list medications: _____

☐ Y ☐ N **Are you pregnant or currently nursing?**

☐ Y ☐ N **Have you ever had chemotherapy?**

If yes, when: _____

☐ Y ☐ N **Have you ever had any radiation therapy?**

If yes, When: _____

What body part: _____

☐ Y ☐ N **Are you allergic to Iodine Contrast?**

If yes, please describe: _____

☐ Y ☐ N **Have you had any recent lab work?**

If yes, indicate where: _____

Do you have any of the following medical conditions?

☐ Y ☐ N Asthma?

☐ Y ☐ N Heart disease or hypertension?

☐ Y ☐ N Decreased kidney function or dialysis?

☐ Y ☐ N Sickle cell disease?

☐ Y ☐ N Liver disease?

☐ Y ☐ N Have you had any other CT, MRI, or PET scans related to today's exam?

Patient name: _____ **Date:** _____

FOR OFFICE USE ONLY. Please do not write below this line.

Dose Label

BG: _____ Weight: _____ Scan Time: _____

Cancer: _____

Radiation: _____

Chemo: _____
Surgery: _____
Contrast: _____ **DLP:** _____
Prior:_____**on Vitrea** ☐ **Yes** ☐ **No**

Verify acc # ☐
Verify weight ☐
Verify mCi ☐
Verify time ☐
Verify images in correct acc # ☐