

PET/CT: QUESTIONNAIRE/AUTHORIZATION

(Office use)

Name: _____ Date of Exam: _____

Date of Birth: ____/____/____ Age ____ Sex: M / F Height: _____ Weight: _____

Referring Physician: _____ Phone Number: _____

Reason for this exam _____

Prior **Surgery or Biopsy?** Yes No

If yes:

What kind of operation(s)? _____

When was it done? _____

Which body part? _____

What was the pathology result? _____

Prior **chemotherapy?** Yes No

If yes, which agents (if known)? _____

When did it start? _____

When did it finish? _____

If currently on chemotherapy, please indicate the date of last cycle _____

Did you receive any bone marrow stimulating drug?

Please specify agent (Neupogen, Epogen): _____

Date of last administration: _____

Prior **radiation** therapy? Yes No

If yes, which body part? _____

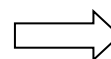
When did it start? _____

When did it finish? _____

Ever had any **trauma, fractures, or recent injuries?** Yes No

If yes, please list with approximate date(s) and part of the body: _____

Continue to Page 2



(Office use)

PET/CT: QUESTIONNAIRE/AUTHORIZATION

Mark if you have any of the following (please specify how long you had this problem)

- Lung disease _____
Lung cancer Asthma Bronchitis Smoker: Yes No How long? _____
- Kidney disease _____
- Liver disease _____
- Reflux /heartburn _____
- Thyroid problems _____

Please list your **medications**, and the reason why you take them:

If you are Diabetic, how is your diabetes treated?

Pills? Yes No Type: _____

Insulin? Yes No How much: _____

Diet and Exercise? Yes No

What is your fasting blood sugar/glucose? _____

Do you have any known allergies (medication, shellfish or other foods)? Yes No

If yes, please specify _____

Any recent intramuscular injection in the last 2 weeks? Yes No

Please specify body part and if for vaccine, B12 injection, etc.: _____

FEMALE PATIENTS ONLY

Are you pregnant? Yes No

Last menstrual cycle: _____

I authorize Weill Cornell Imaging at NewYork-Presbyterian, its physicians, and other staff to perform the prescribed examination.

Questionnaire Completed By:

_____/_____/20_____
Print First and Last Name Signature Date

(Office use)

PET/CT: QUESTIONNAIRE/AUTHORIZATION

DO NOT WRITE BELOW THIS LINE (Office Use Only)

Accession Number: _____

NURSING NOTES:

Blood Glucose: _____

IV site: _____

Infiltration Yes No

Oral contrast administered by: _____ RN

Dose and Concentration: _____

Intravenous contrast administered by: _____ MD RN

Dose and Concentration: _____

Notes:

Nurse: _____ Signature: _____

Date: _____ Time: _____

PET TECHNOLOGIST NOTES:

Isotope: _____ Dose: _____ Post Syringe: _____ Net Dose: _____

Time Injection: _____ Site of Injection: _____

Infiltration: Yes No

Technical Problems? (Please explain):

Technologist: _____ Signature: _____

Date: _____ Time: _____