

(Office use)

## PET/CT: QUESTIONNAIRE/AUTHORIZATION

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: \_\_\_\_\_

\_\_\_\_\_

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**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:

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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

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### DO NOT WRITE BELOW THIS LINE (Office Use Only)

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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:

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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):

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Technologist: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Time: \_\_\_\_\_