PATIENT INFORMATION FORM

CORNER CHURCHILL ROOSEVELT HIGHWAY & DON MIGUEL EXTENION, EL SOCORRO
GIVING HOPE A FIGHTING CHANCE

TODAY'S DATE: D / M / Y

PATIENT INFORMATION

PATIENT'S LAST NAME:	FIRST:	❑ Ms. ❑ Mrs. ❑ Mr.

SEX:	BIRTH DATE:	NATIONALITY:
❑ Male ❑ Female	D / M / Y	

REPORT

❑ COLLECTING BY HAND ❑ BOTH

❑ EMAIL: ____________________

MOBILE NO	HOME PHONE NO.	ADDRESS

OCCUPATION	REFERRING DOCTOR/INSTITUTION

IN CASE OF EMERGENCY

NAME OF RELATIVE OR FRIEND	RELATIONSHIP TO PATIENT:	HOME PHONE NO.:	WORK PHONE NO.:

HOW DID YOU HEAR ABOUT ALEXANDRA IMAGING?

DIGITAL BILLBOARD ❑ BROCHURES ❑ STATIC BILLBOARD ❑ REFERRED BY DOCTOR ❑

ANOTHER PATIENT ❑ OTHER ❑ ____________________

FOR ALEXANDRA IMAGING USE ONLY

CUSTOMER:	FRONT DESK:
PRINTED IMAGES: ❑ YES __________ CD: ❑ YES __________	❑CASH__________ ❑US __________
EMAILED TO PATIENT: ❑ YES ____________________	❑CREDIT CARD__________
FAXED: ❑ __________	❑LINX __________ ❑CHQ # __________
EMAILED: TO DOCTOR ❑ ____________________	❑PRECERTIFICATION __________

PLEASE TURN OVER TO COMPLETE QUESTIONNAIRE

PET/CT SCAN PATIENT SAFETY QUESTIONNAIRE

Please answer the following Questions:

QUESTION		YES	NO	DETAILS
DO YOU HAVE, OR HAVE YOU EVER HAD:				
Are you Diabetic? (Type)				
Do you take insulin? (If yes what time did you take it)				
Do you take oral diabetic medication? (if yes name them)				
Do you take Neupogen, Leukine or Neulasta after Chemo?				
Reaction X-Ray Contrast?				
Do you have a history of tumors or cancer in your body? **If yes, please list them with year of diagnosis:**				
List any surgeries or biopsies? In the past 6 mths related to your cancer:				
Have you had radiation therapy? When was your last radiation therapy?				
What part of your body received radiation therapy?				
Have you had chemotherapy? When was your last chemotherapy therapy?				
Do you have differculty lying still for 20-30 minutes?				
Any History of recent Diarrhea in past 2-3 days?				
History of Claustrophobia?				
Do you smoke?				
Female Patients	Pregnant or suspect to be?			**LMP?**
	Are you breast feeding?			**Weight?**

Most recent PET Scan? D / M / Y **What Facility?** **Part of Body?**

Most recent CT Scan? D / M / Y **What Facility?** **Part of Body?**

Most recent MRI Scan? D / M / Y **What Facility?** **Part of Body?**

I CONFIRM ALL THE ABOVE INFORMATION I HAVE GIVEN IS CORRECT AND HEREBY CONSENT TO THE PET/CT EXAMINATION (S).

PATIENT SIGNATURE: ______________________________ **Date:** ____________________

ON BEHALF OF PATIENT: ______________________________ **Date:** ____________________

*TECHNOLOGIST INJECTION INFORMATION

Questionnaire must be reviewed with patient. Technologist Initials:__________
(Make sure the questionnaire has been completed)

IV Site: ____________________ Initial Assay;____________________ mCi Assay Time: ____________________
Glucose Level:____________________ Post Assay: ____________________ mCi: **Injection Time:** ____________________
Volume Injected:____________________ Injected:____________________mCi **Scan Start Time** : ____________________

Time between Injection and Start of Exam ____________________ **min CTDI** ____________________ **DLP** ____________

Contrast __________ cc __________No Contrast ☐2D ☐3D

Technologist SIGNATURE : ______________________________ **Radiologist SIGNATURE** :______________________________