PET/CT FDG Brain Questionnaire Form

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PET/CT POL.002 Effective Date: August 1, 2013

Patient Name: __________________________ Today’s Date: ______________________

When is your follow-up appointment & who is the doctor? ______________ Date & Time: ______

Are you allergic to any medications? If yes, please list them: ______________________________

☐ YES ☐ NO Are you diabetic? Height: _______ Weight: _______
☐ YES ☐ NO Do you take insulin?
☐ YES ☐ NO Do you take oral diabetic medications?

Do you have a history of tumors or cancer in your body? If yes, please list them with year of diagnosis:
____________________________________________________________________________________________

Do you know why your physician ordered this exam?: ______________________________
____________________________________________________________________________________________

What symptoms have you been experiencing recently? ______________________________
____________________________________________________________________________________________

When was your most recent Brain PET exam? ___________ What facility? ______________

When was your most recent Brain MRI exam? ___________ What facility? ______________

When was your most recent Brain CT exam? ___________ What facility? ______________

FEMALE PATIENTS:
☐ YES ☐ NO Is there any possibility you could be pregnant? LMP? ______________
☐ YES ☐ NO Are you breastfeeding?

Please indicate whether you have a history of any of the following: (Please indicate what type)

☐ YES ☐ NO KIDNEY FAILURE
☐ YES ☐ NO DIABETES
☐ YES ☐ NO INSULIN DEPENDENCE
☐ YES ☐ NO REACTION- X-RAY CONTRAST

**TECHNOLOGIST INJECTION INFORMATION**

Questionnaire must be reviewed with patient. Technologist Initials: _______________________
(Make sure the questionnaire has been completed, and it matches Intake Form and Body Sheet)

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 ________