LENOX HILL RADIOLOGY & MEDICAL IMAGING ASSOCIATES P.C.

NUCLEAR MEDICINE SCREENING SHEET

COMPLETED BY PATIENT

PATIENT NAME: DATE:

DATE OF APPOINTMENT: / / DATE OF BIRTH: / / AGE:

REFERRING PHYSICIAN: PHONE #:

Weight? lbs.

Are you pregnant? ☐YES ☐NO

Have you been breast feeding in the last 6 months? ☐YES ☐NO

THYROID SCAN PATIENTS ONLY

Are you taking thyroid medicine presently? ☐YES ☐NO

Have you discontinued thyroid medication? ☐YES ☐NO

Date last taken: / / Name of medication:

Any I.V. contrast (x-ray, CT or MRI) in the past 8 weeks? ☐YES ☐NO Date: / /

RENAL SCAN PATIENTS ONLY

Are you taking any blood pressure medicine? ☐YES ☐NO

If YES, name of drug: Date last taken: / /

COMPLETED BY TECHNOLOGIST

Do you have a clearly stated written referral? ☐YES ☐NO

What is the clinical question?

Does the study make sense in light of clinical info provided? ☐YES ☐NO

Does the patient have pain? ☐YES ☐NO Where?

Does the patient have any history of Cancer? ☐YES ☐NO

What kind?

Has the patient had any surgery? ☐YES ☐NO

Type: Date(s): / /

Has the patient had chemotherapy? ☐YES ☐NO Last date: / /

Has the patient had radiation therapy? ☐YES ☐NO Last date: / /

Have you explained exam to patient? ☐YES ☐NO

Technologist notes:

Technologist initials:

SCREENED BY: SCREENED WITH:

I verify that the answers I have provided to questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patients signature: Date: / /