Summit Imaging
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CONSENT FOR CONTRAST STUDIES

Your physician has referred you for an examination during which you will receive an injection of a non-ionic contrast material into a vein. Minor sensitivity reactions such as hives, swelling, itching, or skin rash are rare but may occur. We recommend that you notify your primary care provider, should you experience any type of contrast reaction. These reactions may require medications, but will usually disappear within a few minutes of the injection. More serious allergic reactions, such as anaphylactic shock, are rare occurrences and medication is readily available to treat these conditions.

It is important that you drink large amounts of fluids in the next 24 hours to flush the contrast through your kidneys. Please inform the technologist if you are: on Glucophage, Glucovance or Metaformin; if you have any allergies; if you have asthma; if you are pregnant or breast feeding; have kidney disease or have anemia or diseases that affect the red blood cells or if you have had a prior reaction to the contrast materials used for these studies.

While this information may concern you, we believe it to be in your best interest to be informed and to understand what is involved. Naturally, you may refuse permission to perform this test or you may change your mind before the procedure. It is worth knowing that the risk of any serious complication occurring is extremely small.

Would you like to have further information? ☐ Yes ☐ No

I, _____, have read and understand the above. I give my consent to have the exam performed on me. I understand that in spite of every skill and effort made to avoid complications during the examination, occasional complications do occur.

Patient Signature: _____ Date: _____

Print Name: _____

If not patient, indicate relationship: _____

Witness: _____

PET/CT FDG Scan Questionnaire Form

Patient Name: _____ Today's Date: _____

Reason for PET/CT scan? _____

Height: _____ Weight: _____

☐ YES ☐ NO **Are you diabetic?** (Type) _____
☐ YES ☐ NO **Do you take insulin?**
☐ YES ☐ NO **Do you take oral diabetic medications?**
☐ YES ☐ NO **Do you take Neupogen, Leukine or Neulasta after chemo?**

_____

_____

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

_____

List any surgeries or biopsies with dates in the past 6 months and any surgery with date related to your cancer: _____

☐ YES ☐ NO **Have you had radiation therapy**? When was your last radiation therapy? _____

_____

What part of your body received radiation therapy? _____

☐ YES ☐ NO **Have you had chemotherapy**? When was your last chemotherapy? _____

When was your most recent **PET Scan**? _____ ☐ No recent PET

When was your most recent **CT Scan**? _____ ☐ No recent CT
What part of your body? _____

When was your most recent **MRI Scan**? _____ ☐ No recent MRI
What part of your body? _____

FEMALE PATIENTS:
☐ YES ☐ NO **Is there any possibility you could be pregnant?** LMP? _____
☐ YES ☐ NO **Are you breastfeeding?** (Follow special instructions given at scheduling.)

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: _____

Injected: _____ mCi Scan Start Time : _____

Time between Injection and Start of Exam _____ min CTDI _____ DLP _____

_____ No Contrast ☐ 2D ☐ 3D

_____ 16 oz Oral Water *By (Technologist):* _____