BRAIN PET/CT SCAN QUESTIONNAIRE

PATIENT GENERAL INFORMATION

NAME: _____
Last Name First Name Suffix

SEX : F M	AGE: _____	DATE OF BIRTH:	_____/_____/_____ MONTH DAY YEAR	WEIGHT: _____	KILOS	LBS

ADDRESS: _____
Street Name Number City State Zip Code

EMAIL: _____

PHONE NUMBER (1): _____ PHONE NUMBER (2): _____

PATIENT MEDICAL HISTORY

HAVE YOU PREVIOUSLY HAD ANY IMAGING DONE AT SCANTIBODIES? YES | NO ¿WHICH? _____

NAME OF REQUESTING PHYSICIAN FOR PET/CT SCAN: _____

PHYSICIANS PHONE NUMBER: _____ PHYSICIANS EMAIL: _____

MEDICAL DIAGNOSIS/TYPE OF CANCER:

REASON FOR THE STUDY:

Have you received **CHEMOTHERAPY**?	YES	NO	Are you able to move around by yourself?	YES	NO
DATE OF LAST SESSION: _____/_____/_____ MONTH DAY YEAR			Do you use any assistance device to move?	YES	NO
			If so, state device needed. _____		
Have you received **RADIATION THERAPY**?	YES	NO	Are you currently hospitalized?	YES	NO
DATE OF LAST SESSION : _____/_____/_____ MONTH DAY YEAR			Do you require supplemental oxygen?	YES	NO
			Women, are you currently pregnant or lactating?	YES	NO
In which part of the body did you receive radiation therapy? _____			Do you suffer from allergies?	YES	NO
			If so, state allergies. _____		
Are you able to understand /follow instructions?	YES	NO	Are you bedridden?	YES	NO
Are you left-handed?	YES	NO	Do you have involuntary movements? If the answer is yes, anesthesia will be necessary.	YES	NO

Do you think you will need anesthesia during PET/CT scan? YES NO Reason: _____

PLEASE INDICATE ANY SURGERIES UNDERGONE RECENTLY: (Biopsies, tattoos, piercings, dental, any procedure requiring stitches):

TYPE OF SURGERY: _____ **DATE:** _____/_____/_____ MONTH DAY YEAR

Do you suffer from **DIABETES**? : **YES** **NO**
If so, please indicate treatment used for your diabetes: _____

Please indicate your glucose levels for the last 5 days:

Day 1: _____/ **Day 2:**_____/ **Day 3:** _____/ **Day 4:** _____/ **Day 5:** _____

INVOICE INFORMATION – IF NEEDED

NAME: _____
Last Name First Name Suffix

TAX ID NUMBER: _____ EMAIL: _____

PATIENT SIGNATURE	**DATE** _____/_____/_____ MONTH DAY YEAR

Please send documents to the following email: citas@imagenologiayterapia.com

PREPARATION FOR PATIENTS (BRAIN PET SCAN)

PET SCAN MAY BE CANCELLED AND DEPOSIT LOST IF PATIENT IGNORES OR OVERLOOKS ANY OF THE INDICATIONS STATED BELOW.

IMPORTANT NOTES:

- Only patient will be allowed entrance to the building, no companions allowed. Only exceptions are if patient is underage or if patient has a disability.
- No underage children (18+) or pregnant women permitted as patient companions.
- **NO EXCEPTIONS: must wear face mask covering nose, mouth and chin completely.**
- Patients **MUST** have recent MRI scan.
- **Patients with diabetes:** scan will not be performed and deposit will be lost if glucose levels are above 150mg/dl.
- **Pregnant women:** scan cannot be performed due to high risk to fetus.
- **Women lactating:** must inform Scantibodies at least 3 days before your appointment for special instructions.
- **Anesthesia:** requires previous anesthesiologist appointment and extra cost.
- **Myasthenia gravis:** must inform Scantibodies personnel if patient suffers from myasthenia gravis.
- Programming process requires previous appointment via phone or email.
- Must arrive to appointment 10 minutes before scheduled time.
- If patient cancels scan once appointment is confirmed deposit will be lost, no exceptions.

DAY BEFORE PET SCAN:

- Avoid any sugars and food high in carbohydrates **24 hours before** the scan.
- No smoking or drinking alcoholic beverages/caffeine **12 hours before** the scan
- No strenuous physical activity **24 hours before** the scan.

DAY OF PET SCAN:

- **Total fasting of 8 hours** (includes chewing gum).
- **Do not suspend medication** even with fasting; diabetic patients see instructions on second page.
- **Hospitalized patients:** do not administer IV fluid/drip 8 hours prior to scan.
- Must wear comfortable clothing without metals, embellishments or metal zippers. (Ex: sportswear, pijamas, etc.)
- Patient is not permitted to wear jewelry or any type of decorations. Preferably avoid wearing makeup to scan.
- Patients with long hair must wear it in a bun during appointment.
- Must bring medical order requesting PET scan given by attending physician.
- Please bring any previous scans, lab work, biopsies etc. Scans may be in disc, images or written reports. Documents will be checked during appointment and will be returned before scan is over. (Ex: MRI, CT scan, ultrasound, etc.)

PATIENT SIGNATURE: _____ **DATE:** _____

AFTER PET SCAN:

- **No contact with children under the age of 18 or pregnant women for 8 hours after the PET scan.**
- Avoid crowded places for 8 hours after the PET scan.
  (Ex: shopping malls, restaurants, movie theaters, social events, airports)
- Once PET scan is completed patient will be given folder with images and disc of the scan.
- Results are sent via email in a lapse of **72 working hours.**

PATIENTS WITH DIABETES:

In order to perform PET/CT scan diabetic patients must have a **glucose level below 150mg/dL**.

- Must suspend **INSULIN 4 hours prior** to appointment.
- Must suspend **METFORMIN 24 hours prior** to appointment.
- It is necessary to bring medication/insulin being used by patient the day of the appointment. After completing PET scan patient may continue taking medication as instructed by their doctor.

NOTE: IF POSSIBLE PLEASE MAKE SECOND PAYMENT WITH CREDIT OR DEBIT CARD.

PLEASE SEND ALL DOCUMENTOS TO THE FOLLOWING EMAIL: citas@imagenologiayterapia.com

PATIENT SIGNATURE: _____ **DATE:** _____