



Today's Date: \_\_\_\_\_  
(Fecha)

# Registration Form

## PATIENT INFORMATION

Last Name: _____ <small>(Apellido)</small>	First Name: _____ <small>(Nombre)</small>	M.I.: _____	
Birthdate: _____ <small>(Fecha de Nacimiento)</small>	Age: _____ <small>(Edad)</small>	Sex: <input type="checkbox"/> M <input type="checkbox"/> F <small>(Sexo)</small>	
Address, Apt #: _____ <small>(Domicilio, Numero y Calle)</small>	City: _____ <small>(Ciudad)</small>	State: _____ <small>(Estado)</small>	Zip: _____ <small>(Zona Postal)</small>
Home Phone: _____ <small>(Telefono de Casa)</small>	Cell Phone: _____ <small>(Telefono de Celular)</small>		
Driver's Lic. #: _____ <small>(Numero de Licencia para Conducir)</small>	SSN Patient: _____ <small>(Numero de Seguro Social)</small>		
Employer: _____ <small>(Compañia de Trabajo)</small>	Telephone: _____ <small>(Telefono de su Trabajo)</small>		
Emp. Address: _____ <small>(Domicilio, Numero y Calle)</small>	City: _____ <small>(Ciudad)</small>	State: _____ <small>(Estado)</small>	Zip: _____ <small>(Zona Postal)</small>

## INSURANCE INFORMATION

Primary Ins.: _____ <small>(Seguanza Primaria)</small>	Subscriber #: _____ <small>(Numero de a siguranza)</small>	Group #: _____ <small>(Numero de Grupo)</small>	
Insured Name: _____ <small>(Nombre de Su Esposo(a), o Persona Responsable)</small>	Relationship: _____ <small>(Relacion)</small>	Phone: _____ <small>(Telefono)</small>	
Insured Lic. #: _____ <small>(Numero de Licencia para Conducir)</small>	SSN Insured: _____ <small>(Numero de Seguro Social)</small>		
Employer: _____ <small>(Compañia de Trabajo)</small>	Telephone: _____ <small>(Telefono de su Trabajo)</small>		
Emp. Address: _____ <small>(Domicilio, Numero y Calle)</small>	City: _____ <small>(Ciudad)</small>	State: _____ <small>(Estado)</small>	Zip: _____ <small>(Zona Postal)</small>

## MEDICAL INFORMATION

Doctor who referred you to our office: \_\_\_\_\_  
(Nombre del doctor quien lo mando)

Was there an injury?  Yes  No      Date of Injury \_\_\_\_\_      Type of Injury:  WORK  PERSONAL  
(Fue un Herida)      (Fecha de Herida)      (Tipo de Herida)      (Trabajo)      (Personal)

## SIGNATURES

I attest that the information provided on this form is true to the best of my knowledge. I understand that ALL fees are due from ALL PATIENTS as services are rendered, unless prior arrangements have been made with this office. I understand that Insurance Authorization does not guarantee payment and I am responsible for all charges. Please Return this form with your Driver's License and Insurance Card.

(Atesto que toda la informacion en esta forma es real y verdadera de acuerdo a mi conocimiento. Entiendo que todos las tarifas de los servicios son desponibles al tiempo que los servicios son realizados. Entiendo que autorizacion del seguro no garantiza el pago y que yo soy responsable por todos los cargos. Favor de regresar esta forma con su lisencia de conductor y tarjeta de su seguro medico.)

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date



# PET/CT Screening and History

PATIENT NAME: \_\_\_\_\_ D.O.B.: \_\_\_\_\_ WEIGHT: \_\_\_\_\_

HAVE YOU BEEN HERE BEFORE?  YES  NO If YES, then when? \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

## Please answer the following

YES  NO Are you diabetic? Type: \_\_\_\_\_

YES  NO Do you take insulin? \_\_\_\_\_

YES  NO Do you take oral glucose medications?

YES  NO Do you take GCSF (Neupogen Granulocytic Colony Stimulation Factor)?

YES  NO Do you have Kidney Failure? Explain: \_\_\_\_\_

YES  NO Reaction to X-Ray Contrast? Explain: \_\_\_\_\_

YES  NO Do you have a history of tumors or cancer in your body? If YES, please list with the year of diagnosis.

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

YES  NO Have you had radiation therapy? If YES, then when was your last radiation therapy?

What part of your body received radiation therapy? \_\_\_\_\_

YES  NO Have you had chemotherapy? If YES, when was your last chemotherapy? \_\_\_\_\_

When was your most recent PET Scan? \_\_\_\_\_ Facility Name: \_\_\_\_\_

When was your most recent CT Scan? \_\_\_\_\_ Facility Name: \_\_\_\_\_

When was your most recent MRI Scan? \_\_\_\_\_ Facility Name: \_\_\_\_\_

## FEMALE PATIENTS:

YES  NO Is there any possibility you could be pregnant? Last Menstrual Date: \_\_\_\_\_

YES  NO Are you breast feeding?

## TECHNOLOGIST INJECTION INFORMATION

IV Site: \_\_\_\_\_ Initial Assay: \_\_\_\_\_ mCi Assay Time: \_\_\_\_\_

Post Assay: \_\_\_\_\_ mCi

Glucose Level: \_\_\_\_\_ Injected: \_\_\_\_\_ mCi Injection Time: \_\_\_\_\_

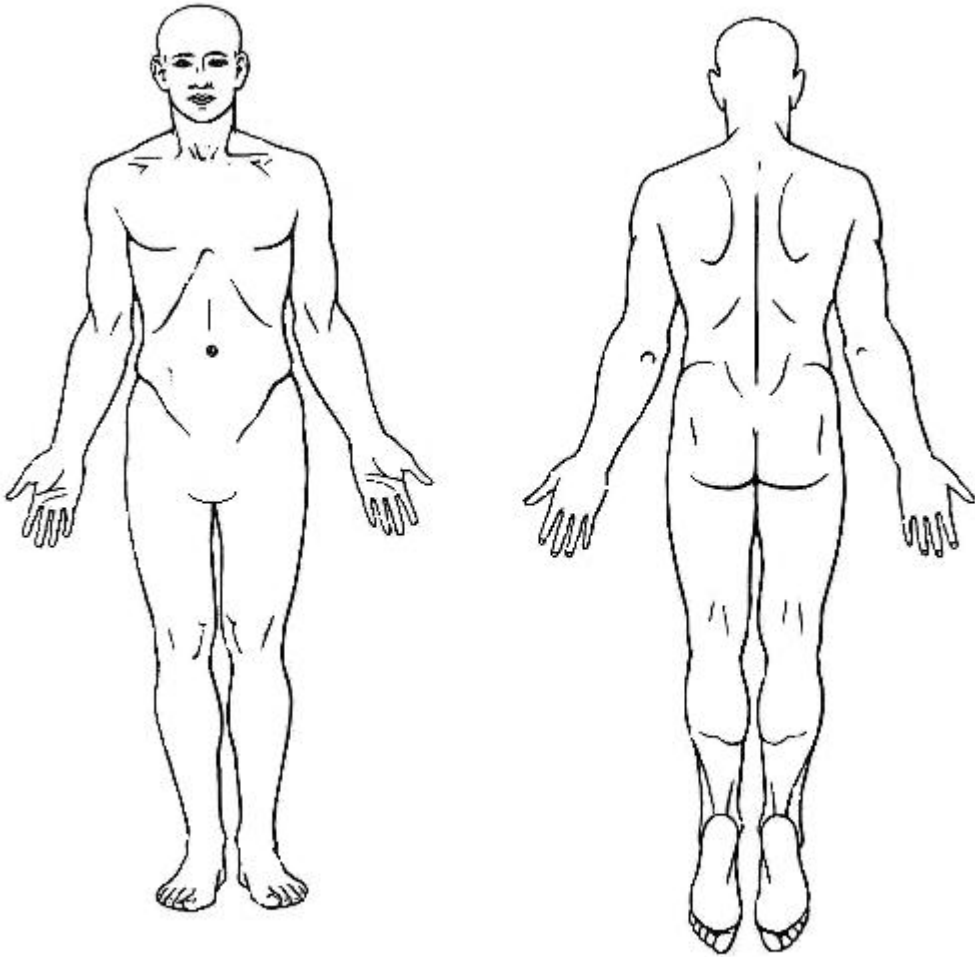
Volume \_\_\_\_\_

Injected: \_\_\_\_\_ Post Assay Time: \_\_\_\_\_

Technologist Signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Please indicate locations of biopsies, surgeries, incisions, and/or ectomies on diagram below:



Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## PET / CT Consent

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

This PET/CT examination is done by using a special computer, which allows us to view internal organs, typically not visualized using standard imaging techniques.

ALL PET/CT examinations require the injection of radioisotope (tracer) into your bloodstream. The use of this tracer helps us to visualize certain organs inside the body, which are not normally well viewed, and provides the radiologist with information necessary in evaluating your exam.

This tracer is given through a small needle placed into the vein, usually on the inside of your elbow or on the back of your hand. The tracer is considered quite safe; however any injection carries a risk of harm including injury to a nerve, artery or vein, or infection or reaction to the material being injected. These reactions are very rare.

Please answer the following questions so that we may evaluate if you are at high risk for adverse effect to the contrast material:

- YES    NO   Have you ever had an “allergic” reaction to any contrast material, which required treatment?
- YES    NO   Do you have allergies or asthma?
- YES    NO   Do you have a history of heart disease or high blood pressure?
- YES    NO   Do you have a history of myeloma, sickle cell disease, polycythemia, or pheochromocytoma?
- YES    NO   Do you have a history of kidney disease or diabetes?
- YES    NO   Is there any chance that you are pregnant?
- YES    NO   Are you breast feeding?

Your doctor has ordered this PET/CT exam, to secure more information, which will aid in the diagnosis of your condition. If you have additional questions regarding your exam, please feel free to discuss them with the Technologist or Radiologist prior to your scan.

I have read and understand the above information, and have answered the questions to the best of my knowledge. I hereby give consent to the prescribed treatment or procedure and release SVR Imaging from liability to any of the above listed potential injuries or reactions.

\_\_\_\_\_  
Signature or Patient or Guardian

\_\_\_\_\_  
Date