Yale NewHaven Health

PET Scan Contrast Questionnaire

Patient's name: _____ **Exam Date:** _____

DOB: _____ **MRUN:** _____

Please answer all questions about the person who will have the PET Scan. Please answer all questions on the front and back of the form.

1. Have you ever had to drink a liquid (contrast) for an x-ray exam? (CT Scan, Upper GI Series, PET Scan, etc.) ◯ Yes ◯ No ◯ I don't know
   If Yes, did you experience any side effects? ◯ Yes ◯ No ◯ I don't know

2. Do you have any allergies? ◯ Yes ◯ No ◯ I don't know
   If Yes, to what are you allergic?
   _____

3. Are you taking any medicine(s) now? Please write the names(s) of the medicine(s) you are taking: ◯ Yes ◯ No ◯ I don't know
   _____

4. Have you had anything to eat or drink in the last 6 hours? ◯ Yes ◯ No

5. Have you had:
   any **surgeries** during the last year? ◯ Yes ◯ No ◯ I don't know
   When? _____
   recent **biopsies**? ◯ Yes ◯ No ◯ I don't know
   When? _____
   chemotherapy? ◯ Yes ◯ No ◯ I don't know
   When? _____
   radiation therapy? ◯ Yes ◯ No ◯ I don't know
   When? _____

6. Do you have a catheter, pacemaker, ostomy, prosthesis or metallic implant? If Yes, where do you have it? ◯ Yes ◯ No ◯ I don't know
   _____

7. Have you had any **infection, inflammation, or injuries** lately? ◯ Yes ◯ No ◯ I don't know
   If Yes, when and where do you have it?
   _____

8. Do you have **diabetes**?
If Yes, when did you last take medication? _____ ◯ Yes ◯ No ◯ I don't know

9. Have you done any exercise or physical activity in the last 24 hours? ◯ Yes ◯ No ◯ I don't know

FOR WOMEN ONLY

Are you pregnant or is it possible you might be pregnant? ◯ Yes ◯ No ◯ I don't know
If yes, or if you are not sure, please tell the technologist now!

Are you breast-feeding? ◯ Yes ◯ No ◯ I don't know
If yes, please tell the technologist now!

Are you menstruating? Date of last cycle: _____ ◯ Yes ◯ No ◯ I don't know

Have you had or are you? ◯ Hysterectomy ◯ Tubal ligation ◯ Post-menopausal

I have read and I understand the information on this form.

Print Form **Reset Form**

_____
Name of person completing the form

_____ _____
Signature of the person completing the form (Relationship to patient)

For Department of Radiology use only. Do not write below this line.

Height: Weight: Glucose:

Indication: Protocol:

Urine POCT performed? ☐ Yes ☐ No ☐ Waived Results: ☐ Positive ☐ Negative

Oral Contrast used: _____ volume (cc) _____ Oral x 1 for procedure

Thyroid P.E.T scans only: Did patient receive Thyrogen? ☐ Yes ☐ No

Injection & Scan Info.

Dose:

	Activity	Time
Pre Inj	mCi	
Inj Time		
Post Inj	mCi	
TAD	mCi	

Radiopharm: ☐ **F-18 FDG** ☐ _____

Injection Site: _____

Injection to scan time _____ minutes

_____ _____ _____ _____
Technologist's Name (Print) Technologist's Signature Date Time

For patients with a Portacath:

- Flush the portacath with 10 mL's of normal saline solution; followed by the installation of 5 mL's of Heparin (100 units / mL).

_____ _____ _____ _____
Nurse's Name (Print) Nurse's Signature Date Time