



"The Leader in Quality Medical Imaging"

Label

Clinical Informed Consent for PET Scanning

This is a procedure in which pictures will be made of a part of my body after a radioactive metabolic tracer has been given to me. The pictures will show the pattern glucose metabolism in my body. My physician has recommended that I have this test because I may have a disorder that alters its metabolism. The results may help my physician determine the existence, location and extent of disease. This will help in choosing the most effective therapy.

A positron emission tomography (PET) scanner will record images of my body. This is a device for creating cross-sectional pictures of the distribution of the metabolic tracer. The scanner looks like a box with a bed which will carry me through a circular opening in the center. The test typically takes 1½ to 2 hours to complete. There is no alternate imaging method to PET which can provide the same type of information.

A small amount of radioactive metabolic tracer will be injected into my body via an intravenous catheter or needle placed in a vein in my arm. The Federal Drug Administration (FDA) has determined this compound to be safe and has approved this drug for certain procedures. PET Centers throughout the country perform thousands of PET scans with these compounds and have had no adverse effects in subjects having this procedure.

The dose or amount of radiation I will receive will be similar to that received during chest and abdomen x-ray examinations. The dose to my pelvis will be comparable to the dose received from a CAT scan of that area. I understand that half the radioactivity will disappear in 2 hours or less and the radioactivity will completely disappear in 12 hours.

FOR WOMEN OF CHILDBEARING AGE: Doses of radioactivity up to 20 times greater than that which I will receive have not resulted in any detectable fetal abnormalities in an unborn child. The physicians conducting the test that I am about to have would, however, like to minimize any potential possibility of exposure of a fetus (unborn child) to even those low levels of radioactivity. Thus, I certify by signing this consent that, to the best of my knowledge, I am not pregnant and that I have, since my last menstrual period, used a medically acceptable and effective method of contraception (birth control) or have not had sexual intercourse.

BY SIGNING BELOW, I UNDERSTAND THAT ALL MEDICAL PROCEDURES MAY INVOLVE DISCOMFORTS AS WELL AS RISKS. I HAVE HAD SUFFICIENT OPPORTUNITY TO DISCUSS THE PROPOSED PROCEDURE AND RISKS WITH MY PHYSICIAN AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

I acknowledge, by my signature, that I understand the above information and that I am freely and knowingly giving my consent to have this PET scan procedure. I also attest that I have complied by the instructions given to me and have not eaten for at least 6 hours prior to my scheduled PET procedure.

Patient's Printed Name

Patient's Signature/Legal Representative

Date



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PET Patient History Sheet

Patient Name: _____ DOB: _____

Weight: _____ Height: _____

(Female Patients)

Is there any chance that you could be pregnant? Yes No	Are you menopausal? Yes No
Are you currently breast-feeding? Yes No	Last menstrual Period: _____

Reason for this exam: _____

Any current or prior Surgery or biopsies? **Yes** **No**

If yes, **When:** _____

What type: _____

Chemotherapy? **Yes** **No** If yes, **When** was last treatment? _____

Radiation Therapy? **Yes** **No** If yes, **When** was last treatment? _____

Neupogen, Epogen, Procrit, or GCSF injections in the last four weeks? **Yes** **No**

Do you have any of the following:

▷ Colostomy	Yes	No
▷ Diabetes	Yes	No

▷ Implants	Yes	No
▷ Urinary Incontinence	Yes	No

▷ Bone Pain	Yes	No	If New How Long: _____
▷ Drains/Open Wounds	Yes	No	Location: _____
▷ Indwelling Catheter or Port	Yes	No	Location: _____
▷ Infections	Yes	No	Location: _____
▷ Joint Replacements	Yes	No	Location: _____

Any other major illnesses: _____

Please list medications you are currently taking: _____

Any food or drink today other than water? **Yes** **No** If yes, what: _____

What time: _____

Would you like us to send a copy of your exam report to your Primary Care Physician?

Dr. _____ (First and last name please)

PATIENT HISTORY



Patient label

Height: _____ Weight: _____

Reason for Study: _____

Have you had recent imaging procedures for these symptoms such as X-Ray, CT or MRI of the affected area? YES NO If YES, Please list date & location below.

Are you providing prior films or images on CD? YES NO

For Female Patients -

Is there a chance you are pregnant? YES NO Breastfeeding? YES NO

Date of last menstrual cycle: _____

Post menopausal or Hysterectomy YES NO

Would you like us to send a copy of your exam report to your Primary Care Physician? No Yes fax to Dr. _____

First and last name please

Check all that applies to you:

- Lump or Mass, Biopsy
- Cancer
- Radiation Therapy
- Chemotherapy
- Surgery
- Infection
- Injury or Accident
- Seizure
- Stroke
- Multiple Sclerosis
- Sports Related Injury

ALLERGIES: _____

Patient Signature _____ **Date** _____

Technologist Use Only

Tech _____ Date _____ Labs Needed? YES NO

IF yes Outside Labs dated _____ Sun Radiology Piccolo BUN ___ Creat ___
Contrast Type _____ How administered _____ Amount _____
Contrast Reaction? YES NO If Yes explain _____

Tech Notes

_____ Tech Signature _____