PET/CT Part A - RETAIL

Last Name: _____

First Name: _____

DOB: _____ Date: _____

Height _____ Weight _____ lbs/kgs

Please answer the following screening questions carefully:

Any medical/dental procedures in the past 24 hours? ☐ Yes ☐ No

List any previous surgeries and their dates: _____

_____

When was the last time you had something to eat or drink except water? _____

Pregnant or Nursing? ☐ Yes ☐ No LMP _____ *(Pregnant patients require informed consent)*

Diabetes? ☐ Yes ☐ No If yes, date and time of last insulin: Injection _____ Oral _____

Bone marrow stimulation meds (examples: Procrit, Epogen, Neulasta) ☐ Yes ☐ No

Androgen deprivation therapy (ADT) or androgen receptor antagonists? If yes, when?_____ ☐ Yes ☐ No

Estrogen receptor blockers such as Tamoxifen or Fulvestrant? If yes, when? _____ ☐ Yes ☐ No

Any barium studies in the past 72 hours? ☐ Yes ☐ No

Any diarrhea in the past 2-3 days? ☐ Yes ☐ No

Any strenuous exercise in the past 48 hours? ☐ Yes ☐ No

Do you have any recent tattoos? ☐ Yes ☐ No

Any history of claustrophobia? ☐ Yes ☐ No

Any implanted or external medical devices? ☐ Yes ☐ No If yes, when? _____

(portacath, neurostimulator, pacemaker, colostomy bag, cardiac implants, surgical clips, artificial joints, dental work, etc.)

Recent illness, infection or injury? ☐ Yes ☐ No If yes, describe _____

Any falls in the past 30 days? ☐ Yes ☐ No If yes, most recent fall date: _____

Are you currently experiencing any pain? ☐ Yes ☐ No If yes, where? _____

Patient history of cancer? ☐ Yes ☐ No If yes, type and date of diagnosis:_____

Chemotherapy or Immunotherapy? ☐ Yes ☐ No If yes, when? _____

Somatostatin Analogs (*Sandostatin LAR, Signifor LAR or Somatuline Depot*)? ☐ Yes ☐ No If yes, when? _____

Radiation Therapy? ☐ Yes ☐ No If yes, when? _____

History of smoking? ☐ Yes ☐ No

Recent immunization? ☐ Yes ☐ No If yes, when? _____

Any previous imaging study related to the reason for today's exam? ☐ Yes ☐ No

Type of exam _____ Facility _____ Date _____

GENERAL CONSENT/ACKNOWLEDGEMENT

I consent to the ordered exam. I understand that I have the right to refuse or stop the exam at any time and I have the right to ask questions and discuss my concerns.

I have read the screening information and answered the above questions accurately.

I authorize Akumin, its subsidiaries and affiliates to bill on my behalf Medicare, or any other insurance company providing benefits to me, for services performed by Akumin and I authorize payment to be made directly to Akumin. In Medicare assigned cases, Akumin agrees to accept the Medicare "allowable charge" as the full charge.

I understand that I am responsible for the payment of any patient liability including, but not limited to, deductibles, coinsurance or non-covered charges. Self-pay/Cash pay patients are expected to pay for services at the time services are rendered unless prior payment arrangements have been made.

I have been offered a printed copy of Akumin's Notice of Privacy Practices and I acknowledge receipt of the Patient Rights and Responsibilities

I have read and I understand, acknowledge and agree to the content of this General Consent form and have had my questions answered. I give my consent to receive electronic communications and survey invitations if applicable.

Patient Signature: _____ Date: _____ Time: _____

(Parent or Guardian if patient is a Minor or Incapacitated) Relationship: _____