

DIAGNOSTIC IMAGING

REQUIREMENTS

for procedures with or without contrast

Patient First Name					
Patient Last Name					
Date of Birth		Current Height		Current Weight	
Most recent blood pressure		Is the patient pregnant or breastfeeding?		☐ YES	☐ NO
Is this patient diabetic?				☐ YES	☐ NO
If yes, what medications are being used to manage their condition?					
Has the patient had procedures with contrast in the past?				☐ YES	☐ NO
Is this patient allergic to contrast?				☐ YES	☐ NO
Do you authorize creatinine levels to be drawn before the procedure?				☐ YES	☐ NO
Does the patient have any metal or medical equipment that will interfere with the imaging process? Do they have any metal in their eyes?				☐ YES	☐ NO
If yes, explain:					
Is there anything else you would like the radiology providers to know? (claustrophobia, mobility issues, other special needs)?				☐ YES	☐ NO
If yes, explain:					
Has the patient ever had prior related imaging to this referral?				☐ YES	☐ NO
If so, where and when?					
Has this patient ever had surgery in the area being imaged?				☐ YES	☐ NO
Has patient been diagnosed with cancer or had chemotherapy?				☐ YES	☐ NO
If yes, what type of cancer?					
For procedures with contrast only:					
If the patient is diabetic OR over 60 years old, have they had GFR? <i>Please send results of BUN & creatinine within 30 days.</i>				☐ YES	☐ NO
Does this patient have any of the following:					
☐ Pacemaker or defibrillator		☐ Programmable shunts		☐ Aneurysm clips	
☐ Cardiac Stents		☐ Renal issues (if so, please explain):		☐ Metallic implants	
PCP Signature:			Clinic Name:		