ADVANCED MRI AND IMAGING

2821 US HWY 27 North • Sebring, FL 33870
Phone: (863) 385-8000 • Fax: (863) 385-8002

Diagnostic Study Registration Form (CT with IV contrast)

Patient Name _____ Date _____

Date of Birth _____ Age _____ Weight _____ Height _____ Sex: ___Male _____Female

HOME ADDRESS _____ _____

MAILING ADDRESS _____

PRIMARY CARE PHYSICIAN _____

HOME PHONE _____ CELL PHONE _____ BUSINESS PHONE _____

SOCIAL SECURITY NUMBER _____

EMPLOYER - INFORMATION:

CURRENT EMPLOYER _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER PHONE NUMBER _____

SPOUSE - INFORMATION:

SPOUSE'S NAME _____ SPOUSE'S DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SPOUSE'S EMPLOYER _____

SPOUSE'S EMPLOYER PHONE NUMBER _____

INSURANCE INFORMATION:

PRIMARY INSURANCE _____ ID# _____ GROUP# _____

PRIMARY INSURED NAME (IF OTHER THAN PATIENT) _____ RELATIONSHIP _____

PRIMARY INSURED DOB: _____ S S NO _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SECONDARY INSURANCE _____ ID# _____ GROUP# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

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AREA TO BE EXAMINED / TYPE OF EXAMINATION:_____

DIAGNOSIS OR CLINICAL SUSPICION_____

Have you had any previous X-Rays, MRIs, CTs, DEXA or Ultrasounds? _____ Yes _____No

If yes: What _____When _____Where_____

_____Yes _____No Have you ever smoked? If yes for how long?_____ How many packs a day?_____ If you are an ex-smoker, how long ago did you quit? _____

_____Yes _____No Cancer?

If yes: What type _____Where_____

Radiation therapy: _____Yes _____No Chemotherapy: _____Yes___ No____

List recent surgeries:_____

IV Contrast History:
Do you have any personal history of:
_____Yes _____No Asthma and/or allergic respiratory disease
_____Yes _____No Lung disease
_____Yes _____No Myeloma _____Yes _____No Proteinuria_____-
_____Yes _____No **Diabetes**

If yes, do you take oral medication containing Metformin_____Yes _____No
_____ Glucophage_____Metaglip _____ Avandamet _____ Riomet _____ Fortamet_____Glucovance

_____Yes _____No Kidney disease _____Yes _____No Kidney surgery
_____Yes _____No Heart disease, CHF, and or high blood pressure
_____Yes _____No Liver disease? _____Yes _____No Liver transplant/pending liver transplant?
_____Yes _____No Seizure disorder? _____Yes _____No Thyroid disorder?
_____Yes _____No Contrast exam performed within the last 7 days?
_____Yes _____No Are you **pregnant**? Date of last menstrual period:_____
_____Yes _____No Are you currently **breast feeding**?

List any drug allergies:_____
List any food allergies:_____
Have you ever had **an allergic reaction to x-ray contrast (IODINE DYE)**_____Yes _____No
If yes, please explain:_____

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Patients with Diabetes
If you are taking Metformin (Glucophage, Glucovance, etc.) and having a contrast injection in X-ray or CT today, you will be asked to stop taking it for 48 hours post injection of contrast media. This does not apply to MRI contrast injections. Contact your primary physician prior to restarting your Metformin (Glucophage, Glucovance, etc.) to make sure your renal functions are okay.
I will stop my Metformin (Glucophage, Glucovance, etc.) and contact my physician before restarting it.
_____(Initial Here)

IV Contrast Consent

CT examinations often require the use of contrast materials to enhance the visibility of certain tissues or blood vessels. The contrast material may be given as something to drink before your exam, or injected intravenously during your exam. In rare cases, the contrast material may be need to be given in the form of an enema to help visualize the lower colon in the pelvis. The intravenous contrast material contains **IODINE** and some people may be allergic. We screen all of our patients for this prior to administering the intravenous contrast material. We use **non-ionic** contrast material which is proven to be more tolerable. Some reactions such as nausea, vomiting, skin rash, hives, or other more severe reactions can occur, but are very uncommon. With the safety of the new **non-ionic** contrast materials, adverse effects are very rare but can happen.

I have answered the questions on page 1 to the best of my knowledge and understand the information presented to me.
I consent to the use of IV Contrast during my exam.

Patient, Parent or Guardian, Responsible Party Signature_____

Date _____Time_____

_____

For Clinical Use Only (IV CONTRAST PATIENTS ONLY)

Technologist _____

Pertinent history_____
_____ Oral contrast given _____Amount_____
_____Rectal contrast given_____Amount_____
_____IV contrast given: Contrast type _____Amount _____(CCs)
Needle gauge_____ IV site_____
BUN _____CREATININE_____GFR _____ Date_____

Contrast allergy_____Yes _____No
Patient premedicated for exam_____Yes _____No_____

Contrast reaction: _____Yes ____No Discharge instructions given for contrast reaction: ___Yes __NO__

Discharge instructions given for Metformin: _____Yes _____No
Discharge instructions given for nursing mothers ____Yes _____No

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the physician/staff of Advanced MRI and Imaging to send artificial, prerecorded, or automated calls and text messages and to release/leave medical information, with the following (please check applicable):

_____ Spouse

_____ Significant other

_____ Family Member (name: _____)

_____ Caregiver

_____ Answering Machine

_____ Send artificial, prerecorded, or automated calls and test messages.

I understand and acknowledge that should I need to change how I receive my medical information or messages that it will be necessary to notify my provider/office to those changes.

_____

Signature of Patient (of parent/guardian or minor) Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

FOR OFFICE USE ONLY

Print Name: _____

Signature: _____ Date: _____

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PATIENT CONSENT FORM

By signing this form, you are granting consent to Advanced MRI and Imaging to use and disclose your protected health information for the purpose of treatment, payment, and health care operations as well as any ordered testing or imaging

Our notice of privacy practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our notice of privacy practices before you sign this consent.

Our notice of privacy practices is subject to change. If we change our notice, you may obtain a copy of the revised notice from our office.

You have a right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment, or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your original consent.

_____

Patient name (please print above)

_____ _____

Patient Signature Date

_____

Witness name (please print above)

_____ _____

Witness signature Date