X-RAY PROCEDURE SCREENING FORM

PATIENT NAME: ____________________

CHART #: ____________________ EXAM DATE: ____________________

EXAM: ______________ WEIGHT: __________ DOB: __________ DX CODE: __________

REFERRING DR.: __________ PRIMARY DR.: __________ CC: __________

PLEASE LIST ANY SYMPTOMS YOU ARE OR HAVE BEEN DIRECTLY RELATED TO THE EXAM BEING PERFORMED TODAY: ____________________

____

ARE SYMPTOMS INJURY RELATED? ❑ YES ❑ NO

IF YES, DATE OF INJURY: ____________________ TYPE OF INJURY: ____________________

IF NOT INJURY RELATED, APPROXIMATE DATE SYMPTOMS BEGAN: ____________________

HAVE YOU HAD ANY SURGERY ON THE SITE TO BE EXAMINED? ❑ YES ❑ NO

IF YES, TYPE AND APPROXIMATE DATE OF SURGERY: ____________________

PLEASE LIST ANY/ALL OF THE FOLLOWING PROCEDURES YOU HAVE HAD ON THE EXAM SITE:

EXAM	DATE OF EXAM	LOCATION OF EXAM
XRAY		
ULTRA SOUND		
CT SCAN		
MR		
NUCLEAR MEDICINE		

FEMALES:

IS THERE ANY POSSIBILITY OF PREGNANCY? ❑ YES ❑ NO

DATE OF LAST MENSTRUAL PERIOD: ____________________

FOR OFFICE USE ONLY BELOW THIS LINE

Tech Comments: ____________________

INT Size: __________ Location: __________ Irrigates w/o resistance: ❑ Yes ❑ No Tech : __________

Contrast: __________ Amount: __________ Radiologist: __________

INT DC'd: ❑ Yes ❑ No ___ IV within normal limits: ❑ Yes ❑ No Discharge Time: __________

Change from initial assessment? ❑ Yes ❑ No ____________________

TEACHING DATA

Type of procedure: ____________________

Procedure and pre and post preparation explained to:

Patient ❑ Father ❑ Mother ❑ Guardian ❑ Other ❑ ____________________

Tech Signature: ____________________

Verbalizes understanding of procedure and post procedure instructions: ❑ Yes ❑ No