VALLEY
Imaging Center

Diagnostic Imaging Preps

US Prep

Abdomen	NPO 8hrs prior to exam.
Abdomen with Elastography	NPO 8hrs prior to exam
ABD Aorta Duplex	NPO 8hrs prior to exam
Renal	Full bladder, 32oz 1hr prior to exam
Renal Artery Doppler	NPO 8hrs prior to exam
Aorta Duplex	NPO 8hrs prior to exam
Pelvic w & wo TV	Full bladder, 32oz 1hr prior to exam
Echocardiogram	no stimulants; such as energy drinks or coffee on the day of the exam

INJ Prep

LESI/NRB	Patient will need a driver for after the appointment. There can be delayed effects of numbing.
Myelogram	Patient will need a driver for after the appointment. There can be delayed effects of numbing.
Biopsies	No blood thinners.

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CT Patient Screening Form

Height: _____ **Weight:** _____

1. Do you have history of Diabetes? Yes No
2. Do you take any Diabetes Medications? Yes No

   If yes, what type (circle)

Metformin	Glumetza	Glucovance
Glucophage	Fortamet	Actoplusmet
Glucophage XR	Riomet	Avandamet

3. Do you have a history of Asthma? Yes No
4. Do you have a history of Cancer? Yes No

   If yes, what type? _____

   What year was it diagnosed? _____

   What type if treatment have you had? _____
5. Do you have a history of Kidney Disease? Yes No
6. Do you have a history of Multiple Myeloma? Yes No
7. Do you have a history of Pheochromocytome? Yes No
8. Do you have a history of Polycythemia? Yes No
9. List any previous surgeries: _____
10. List any medications you are allergic to: _____
11. Have you had any radiology exams at this facility? Yes No

    If yes, what year? _____
12. Why are you having this CT examination? (Please be specific and list all your symptoms)

_____

_____

_____

Patient/Legal Guardian Signature Date Time

_____

Technologist's Signature Date Time

**********Official Use Only**********

Bun Creatinine GFR Radiologist Signature _____

VALLEY
Imaging Center

MRI PATIENT SCREENING FORM

Height: _____ **Weight:** _____

What symptoms have prompted today's visit? _____

1) Cardiac pacemaker/Implanted Cardiovascular Defibrillator (ICD)/Heart valve/Heart surgery: Yes No

If yes, date/type _____

2) Shunts/Stents/Intravascular coil: **If yes, date/type** _____ Yes No

3) Ear or eye implants/surgery: **If yes, date/type** _____ Yes No

4) Injury to eye involving metal or metal shavings _____ Yes No

5) Brain surgery or aneurysm clips: **If yes, date/type** _____ Yes No

6) Any electrical, mechanical, magnetic pumps, stimulators, and/or implants? Yes No

If yes, date/type _____

7) Any body piercing jewelry? Yes No

8) Any breast tissue expanders? **If yes, date/type** _____ Yes No

9) Bullets, Shrapnel or metal fragments in skin or body? Yes No

If yes, specify _____

10) Dentures/Hearing aid/Wig: **Please circle which applies** Yes No

11) Any type of prosthesis (eye, penile, etc.)? **If yes, date/type** _____ Yes No

12) History of cancer or tumors Yes No

13) Please list anything you are allergic to: _____

14) Respiratory, liver, or blood disorders: **If yes, specify** _____ Yes No

15) Any metallic medication patches? **If yes, specify** _____ Yes No

16) Heart, Brain, Eye, or Ear surgery? **If yes, date/type** _____ Yes No

All other surgeries: _____ Date: _____

Please list dates and locations of prior MRI imaging related to today's exam:

_____ Date: _____

17) Age 60 or older? Yes No

18) History of high blood pressure requiring medication? Yes No

19) History of diabetes? Yes No

20) History of kidney disease including: Yes No

☐Dialysis ☐Kidney Transplant ☐Single Kidney ☐Kidney Surgery ☐History of Kidney Cancer

Patient or Guardian Signature:_____ Date:_____

VUI Tech initials: _____