C.T.REQUEST: BODY

☐BRANDYWINE
☐OMEGA IMAGING
☐PIKE CREEK
☐GLASGOW

Patient#: _____ Date: _____

Name of Patient: _____ Age: ____ Date of Birth: __/__/__

Requesting Doctor: _____ Family Doctor: _____

Why do you need this test?: _____

POSSIBILITY OF BEING PREGNANT: ☐ NO, ☐ YES, Date of last menstruation:_____

CLINICAL INFORMATION: Check if Yes

CHEST:

Coughing blood _____
Shortness of breath_____
Pain (which side?) ☐ Left ☐ Right
Mass (which side?) ☐ Left ☐ Right

ABDOMEN/PELVIS

Nausea/Vomiting ☐
Vomiting blood ☐
Blood in stool ☐
Blood in urine ☐
Jaundice ☐
Diarrhea ☐
Constipation ☐
Pain and side ☐
Mass and side ☐

ALLERGIES: __Yes,__No
Type: _____
Heart Problems __Yes,__No
Kidney Problems __Yes,__No
Asthma __Yes,__No
Allergy to x-ray dye __Yes,__No
Taking glucophage __Yes,__No
Diabetic __Yes,__No

Past History: (give details if known)

Hospitalization or treatment for current problem? _____
Date: _____ Place:_____
Previous surgery? __No, ___Yes What area?_____
Any Known Tumor? __No , ___Yes : What part of the body: _____ Did you have Radiation: __Yes , __No
Any other Surgery? __No , ___Yes : What part of the body: _____ or Chemotherapy: __Yes , __No

ADDITIONAL PERTINENT INFORMATION: _____

PREVIOUS EXAMINATIONS : (give dates and places if known)

	Check if YES:	Date:	Where?
X-ray of	_____	/ /	_____
C.T. of	_____	/ /	_____
Upper G.I.	_____	/ /	_____
Barium Enema	_____	/ /	_____
M.R.I.	_____	/ /	_____
Nuclear Medicine Scan	_____	/ /	_____
Ultrasound	_____	/ /	_____
Others, specify:			

Technologist: _____,R.T.