



PATIENT INFO		PHYSICIAN INFO		INSURANCE
PT. NAME: LAST	FIRST	DR. NAME:	DR. SIGN:	
PT. DOB:		DR. TEL:	ORDER DATE:	
PT. TEL:		DR. FAX:	INDICATION:	

NUCLEAR MEDICINE	PET-CT & CT (64 Slice)	MRI / US / XR
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<p><b>1. BONE SCAN</b>  <b>A. Whole Body B. Three-Phase C. SPECT</b>  <input type="checkbox"/> Metastatic Disease <input type="checkbox"/> Prosthetic Loosening  <input type="checkbox"/> Arthritis <input type="checkbox"/> RSD <input type="checkbox"/> Plantar Fasciitis <input type="checkbox"/> Stress Fx.  <input type="checkbox"/> Diabetic Foot <input type="checkbox"/> Osteomyelitis vs Cellulitis                      (combine w/ Gallium scan #4)  <b>2. BRAIN SPECT</b>  <input type="checkbox"/> Dementia/ Stroke <input type="checkbox"/> DAT Scan for Parkinson's</p> <p><b>3. CARDIAC STRESS TEST</b>                      Thallium / Technetium SPECT <input type="checkbox"/> Pharma <input type="checkbox"/> TMT  <input type="checkbox"/> Chest Pain <input type="checkbox"/> CAD/ Stent/CABG <input type="checkbox"/> Pre-op Eval.  <input type="checkbox"/> Dyspnea on Exertion <input type="checkbox"/> Abn. Resting EKG</p> <p><b>4. INFECTIONS Gallium Scan</b> <input type="checkbox"/> Infection</p> <p><b>5. LIVER AND GALL BLADDER</b>  <b>A. HIDA (Hepato-Biliary) w/G.B. Ejection Fraction</b>  <input type="checkbox"/> RUQ Pain <input type="checkbox"/> Gall Stones / Cholelithiasis  <b>B. Liver -Spleen Scan</b> <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Mass  <b>C. RBC Blood Pool Study</b> <input type="checkbox"/> Hemangioma</p> <p><b>6. MUGA SCAN</b> (For Accurate L.V.E.F.)  <input type="checkbox"/> CHF <input type="checkbox"/> Difficult Echo <input type="checkbox"/> Pre &amp; Post-Chemo LVEF</p> <p><b>7. RENAL / KIDNEY</b>  <b>A. Renal Scan w/ Flow</b> <input type="checkbox"/> Differential Kidney Functn.  <b>B. W / Captopril</b> <input type="checkbox"/> Renal Artery Stenosis - HTN</p> <p><b>8. STOMACH - ESOPHAGUS</b>  <b>A. Gastric Emptying</b> <input type="checkbox"/> Diabetes <input type="checkbox"/> Dyspepsia</p> <p><b>9. THYROID SCANS</b>  <b>A. THYROID CANCER</b>  <input type="checkbox"/> I-131 Whole Body Scan <input type="checkbox"/> I-123 Whole Body Scan  <input type="checkbox"/> Thyrogen Injection I.M. <input type="checkbox"/> WB FDG PET-CT Scan  <input type="checkbox"/> Post I-131 Rx Body Scan <input type="checkbox"/> I-131 Thyroid Therapy _____ mCi  <b>B. HYPERTHYROIDISM</b>  <input type="checkbox"/> Thy. Uptake &amp; Scan <input type="checkbox"/> I-131 Thyroid Rx _____ mCi</p> <p><b>10. PARATHYROID</b>  <input type="checkbox"/> Adenoma <input type="checkbox"/> ↑PTH <input type="checkbox"/> ↑Ca++</p>	<p><b>11. BRAIN PET-CT</b>  <b>A. FDG Brain PET</b>                      Alzheimer's Disease Vs FrontoTemporal Dementia  <input type="checkbox"/> Short term Memory loss &gt; 6 mos. <b>Pls Provide:</b>  <input type="checkbox"/> MMSE Score _____ <input type="checkbox"/> TSH _____  <input type="checkbox"/> Head CT* or MRI* _____ <input type="checkbox"/> B-12 _____  <b>B. AMYLOID Brain PET</b>  <input type="checkbox"/> Identify Alzheimer's B-Amyloid Plaque burden                      * Head CT and/or MRI is required before Brain PETs</p> <p><b>12. MEMORY LOSS DIAG. EVAL.</b>  <input type="checkbox"/> Head CT or MRI/MRA, TCD, Amyloid PET, FDG Brain</p> <p><b>13. CARDIAC PET-CT</b>  <b>A. RUBIDIUM Perfusion PET</b>  <input type="checkbox"/> Chest Pain <input type="checkbox"/> CAD <input type="checkbox"/> SOB <input type="checkbox"/> Pre-op Eval.  <input type="checkbox"/> Abn. Resting EKG <input type="checkbox"/> Inconclusive SPECT  <b>B. FDG Viability PET</b>  <input type="checkbox"/> Infarct Vs Hibernating Myo. Vs Soft tissue atten.</p> <p><b>14. ONCOLOGY PET-CT</b>                      For anatomical details, pls. include CT w/contrast                      Please complete CT order (in Section 15)  <input type="checkbox"/> Breast <input type="checkbox"/> Bladder <input type="checkbox"/> Brain  <input type="checkbox"/> Bone Mets <input type="checkbox"/> Colorectal <input type="checkbox"/> Gastic/Esophagus  <input type="checkbox"/> Head-Neck/Thyroid Ca. <input type="checkbox"/> Liver/Pancreatic Ca.  <input type="checkbox"/> Lung /Pulm. Nodule <input type="checkbox"/> Prostate (post Dx)  <input type="checkbox"/> Lymphoma <input type="checkbox"/> Renal Cell Ca.  <input type="checkbox"/> Ovarian/Cervix/Uterus <input type="checkbox"/> Melanoma  <input type="checkbox"/> Other _____ <input type="checkbox"/> Unknown Primary</p> <p><b>15. CT SCANS</b>                      If ordering PET, please include CT order as needed.                      Contrast <input type="checkbox"/> W/o <input type="checkbox"/> W+W/o                      Patients &gt;60 yrs need BUN, Creatinine, GFR                      Oral Diabetics: No oral meds 24h pre &amp; 48h post cont.  <input type="checkbox"/> Head <input type="checkbox"/> Knee <input type="checkbox"/> High Res. CT  <input type="checkbox"/> Sinus <input type="checkbox"/> Neck <input type="checkbox"/> Liver 3 Phase  <input type="checkbox"/> Chest <input type="checkbox"/> Abdomen <input type="checkbox"/> Pelvis  <input type="checkbox"/> Shoulder <input type="checkbox"/> Hip <input type="checkbox"/> C-Spine  <input type="checkbox"/> CTA Runoff Ab/Pelvis <input type="checkbox"/> T-Spine  <input type="checkbox"/> CTA Runoff Low Exterimity <input type="checkbox"/> L-Spine</p> <p><b>16. INTERVENTIONAL RADIOLOGY</b>  <b>A. Joint Injections:</b> <input type="checkbox"/> Arthrogram <input type="checkbox"/> Therapeutic Inj.  <input type="checkbox"/> Hip <input type="checkbox"/> Shoulder <input type="checkbox"/> Knee <input type="checkbox"/> Other _____  <b>B. Varicose Veins' Ablation:</b>  <input type="checkbox"/> Right leg <input type="checkbox"/> Left Leg <input type="checkbox"/> Both legs  <b>C. Epidural Spinal Injections (Need &lt; 6 mo old MRI)</b>  <input type="checkbox"/> Low back Pain <input type="checkbox"/> Sciatica <input type="checkbox"/> Spinal stenosis  <b>D. Stem Cell Therapy Consultation</b></p>	<p><b>17. MRI</b></p> <p><b>A. HEAD/NECK</b>  <input type="checkbox"/> MRI Brain  <input type="checkbox"/> MRA Brain  <input type="checkbox"/> MRA Neck/Carotid  <b>TIA/Stroke protocol</b>                      Includes all 3 above</p> <p><b>B. BODY</b>  <input type="checkbox"/> Abdomen  <input type="checkbox"/> Pelvis  <input type="checkbox"/> MRCP / Biliary</p> <p><b>C. SPINE</b> <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar</p> <p><b>D. JOINTS</b>  <input type="checkbox"/> Shoulder <input type="checkbox"/> Hip  <input type="checkbox"/> Elbow <input type="checkbox"/> Knee  <input type="checkbox"/> Wrist <input type="checkbox"/> Ankle  <input type="checkbox"/> Hand <input type="checkbox"/> Foot</p> <p><b>E. MRA</b>  <input type="checkbox"/> MRA Brain  <input type="checkbox"/> MRA Neck/Carotid  <input type="checkbox"/> Thoracic Aorta  <input type="checkbox"/> Abdominal Aorta</p> <p><b>18. DOPPLER (Vascular)</b>  <b>A. Carotid Arteries</b>  <input type="checkbox"/> Neck bruit <input type="checkbox"/> TIA <input type="checkbox"/> Syncope <input type="checkbox"/> Prior CVA  <b>B. Transcranial Doppler (TCD)</b>  <input type="checkbox"/> Dizziness <input type="checkbox"/> TIA <input type="checkbox"/> Syncope <input type="checkbox"/> Prior CVA  <b>C. Abdominal Aortic Aneurysm Screen</b>  <input type="checkbox"/> Hx. Smoking <input type="checkbox"/> AAA <input type="checkbox"/> Bruit <input type="checkbox"/> &gt;70 Yrs  <b>D. Lower Extremity – Arterial w/ ABI</b>  <input type="checkbox"/> Claudication <input type="checkbox"/> Numbness <input type="checkbox"/> PVD/PAD  <b>E. Lower Extremity – Venous</b>  <input type="checkbox"/> Pain / Redness / Swelling <input type="checkbox"/> DVT <input type="checkbox"/> Varicose</p> <p><b>19. ECHOCARDIOGRAPHY</b> <i>No Stress Echo</i>                      Resting 2D Echo <input type="checkbox"/> LVH <input type="checkbox"/> CHF <input type="checkbox"/> Valve Dx  <input type="checkbox"/> Hypertension <input type="checkbox"/> Cardiomyopathy</p> <p><b>20. ULTRASOUND</b>  <input type="checkbox"/> Abdomen - <input type="checkbox"/> Limited <input type="checkbox"/> Complete  <input type="checkbox"/> Pelvis - <input type="checkbox"/> Limited <input type="checkbox"/> Complete  <input type="checkbox"/> Other _____ Reason _____</p> <p><b>21. X-RAY</b>  <input type="checkbox"/> Chest - <input type="checkbox"/> AP <input type="checkbox"/> Lat <input type="checkbox"/> Spine _____  <input type="checkbox"/> Shoulder <input type="checkbox"/> Hips <input type="checkbox"/> Knees <input type="checkbox"/> Ankle  <input type="checkbox"/> Other _____</p>
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NOTES

## CHECKLIST / GENERAL INSTRUCTIONS

- Bring your ID and health insurance cards.
- Wear warm and comfortable clothing.
- Arrive 15 minutes before your appointment.
- Bring ALL medicines with you.
- If diabetic, bring insulin with you.

If you are a diabetic on insulin, ask for afternoon appointment. Bring insulin along. If you have special requirements such as children, transportation, a time constraint, upcoming doctor's appointment, large wheel chair, stroke or difficult venous access, please notify us before.

**DUE TO TIME SENSITIVE MEDICINES 24 HOUR NOTICE REQUIRED FOR ALL CANCELLATIONS OR RESCHEDULING REQUESTS. PLEASE SEE GRAY BOX ON BOTTOM.**

### CARDIAC STRESS TEST / THALLIUM / RUBIDIUM SCANS

- Do not eat or drink at least 4 hours prior to scan.
- **No caffeine 24 hours before scan.** No soda, no coffee, no tea, no chocolate.
- You will lie with arms above your head on the scanning table for 15 minutes each time for the two studies.
- Images may be repeated if they are not satisfactory.
- You may be asked to have food either before or after the first images, so please bring a snack or a meal with you.
- Do not take Beta blockers such as Atenolol, Propranolol, Metopro, Inderal, lol, etc. 24 hours before.
- Please bring all your medications and inhalers with you.
- If you are a male patient, your chest may be shaved at some places to put the EKG leads on.
- Wear warm and loose clothes and tennis shoes for the treadmill exercise test. If you are not able to exercise on the treadmill, you will be given a chemical stress test.
- An informed consent for the procedure will be obtained. Usual time to complete test: 2 - 3 hours.

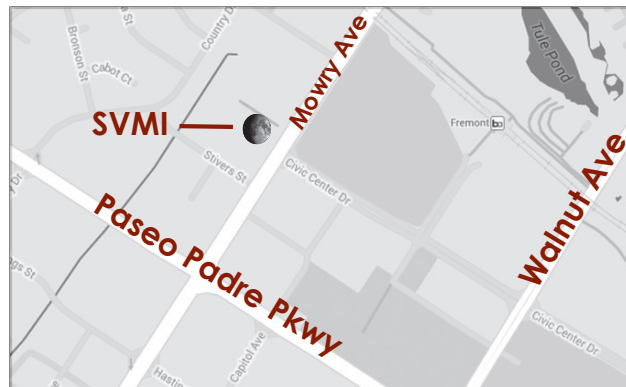
### PET-CT PATIENT PREPARATION

- Nothing by mouth (NPO) except water for 6 hours prior to your appointment.
- Patient CAN drink water that morning.
- Take all necessary medicines only with water.
- Low carbohydrate diet during prior night's meal.
- Refrain from exercise for 24-48 hours prior to test.
- If you are diabetic, and on insulin, ask for an afternoon appointment. (to have early breakfast)
- Bring insulin and all medicines to the clinic.
- Please inform us if you are claustrophobic. Bring a ride/driver along.
- Although the actual scan time is typically 20 minutes, expect to spend approximately 2 to 3 hours at our facility for your PET-CT scan.
- Wear warm clothes, since the scanner room is cold.

### CT SCAN PREPARATION

- Special preparation is NOT required for most CT Scans.
- Wear comfortable and loose-fitting two-piece clothing for your exam.
- Remove metallic clothing or jewelry that may interfere with X-Rays (no belts, earrings, underwire bras, dentures, hairpins, etc.)
- You may be asked to change into a gown.
- For IV contrast for CT, we need renal function tests if you are >65 years of age or have kidney disease or recent infection or hospitalizations.
- For oral contrast, you'll receive detailed instructions at the time of your appointment. Exams of the abdomen and pelvis may require an oral contrast agent as a drink which is given 1-2 hours prior to your scan.
- For abdomen and/or pelvis CT scan, refrain from eating after midnight before the exam. Fluids in moderation are encouraged before the exam.
- **Take plenty of fluids after a contrast exam**
- **Discontinue oral diabetic medication such as Metformin 24 hours before and 48 hours after contrast.**
- **Continue to take all medication ordered by your doctor.**

[www.svmedicalimaging.com](http://www.svmedicalimaging.com)



### DIRECTIONS TO OUR FACILITY:

#### PUBLIC TRANSPORTATION

##### From San Francisco Metro Embarcadero Station

Depart Embarcadero BART - (44 mins)  
Arrive at Fremont BART (about a 5 minute to facility)

##### From Downtown San Jose, 1st St. & Mission

Take 180 Bus to Fremont BART at San Jose Diridon Stn.  
Direction: 180 NB Express Fremont BART  
Arrive at Fremont BART (about a 5 minute walk)

#### DRIVING

**From Oakland** - Take I-880 Southbound  
Exit Mowry Ave exit, Make left at Mowry Ave.  
Go about 1.5 miles, facility on your left.

**From San Jose** - Take I-880 Northbound  
Take the Mowry Ave exit, Slight right at Mowry Ave.  
Go about 1.5 miles, on your left.

Arrive at:

**2191 Mowry Ave. Suite 500-H, Fremont, CA**

### MRI PREPARATION

- **Inform us if you have a pacemaker, heart valve, aneurysm clip or cochlear implant. Inform us if you've had brain, heart, eye, or ear surgery. Inform us if you have any metallic objects or implants.**
- In preparation for your MRI you may be asked to remove make-up and dentures depending on the study. You may also be asked to wear a hospital gown to avoid magnetic interference from buckles, zippers etc.
- Continue to take medication prescribed by your doctor unless directed.
- If you are having a MRI of the abdomen you will be asked not to eat or drink 4 hours prior to the exam.
- Fluids in moderation are encouraged before the exam.
- If you have a history of kidney disease or kidney failure and your exam is scheduled with contrast, please notify us so a technologist can determine whether contrast should be used.
- Once you are situated on the table, make sure you are comfortable so that it is easy to keep still. Breathe normally. There is nothing about the procedure to make you uncomfortable. Once the exam is over, the technologist will assist you out of the scan room.

### ULTRASOUND PATIENT PREPARATION

- **Abdomen:** Nothing by mouth (NPO) for 6 hours before your appointment.
- **Pelvis:** The patient may only drink water (32 ounces).

**We need to order special medical isotopes for your type of test. These isotopes are expensive, and usually expire on the same day and can not be used again.**

**IT IS VERY IMPORTANT THAT YOU RESCHEDULE YOUR APPOINTMENT OR CANCEL BEFORE 4:30 PM THE DAY BEFORE. IF NOT, YOU MAY BE RESPONSIBLE FOR THE COST OF THESE EXPENSIVE MEDICINES.**