ST. JAMES'S HOSPITAL
James's, St. Dublin 8. Ireland.
Tel (+353-1) 410 3000

PET/CT CENTRE- – HOSPITAL 1 GROUND FLOOR
TEL – 01 428 4947

PET/CT SCANNING QUESTIONNAIRE

NAME _____ **DATE OF BIRTH** _____

ADDRESS_____

TELEPHONE NO. _____**MOBILE NO.** _____

REFERRING DR. _____**CONTACT DETAILS** _____

Please answer the following questions as accurately as possible and expand if answering yes :

	Yes	No	Info
Have you been scanned in St. James's Hospital before?			
Have you had a prior PET/CT scan, CT or MRI? When? Where?			
Would you have difficulty lying on a reclining chair for a period of up to 1.5hours?			
Do you have difficulty lying still in the scanner for 20-30minutes?			
Do you have difficulty with mobility and climbing into bed unassisted?			
Are you claustrophobic?			
Have you had major surgery/chemotherapy/ radiation therapy within the past month or a recent biopsy?			
Have you had any episodes of falling?			
Do you have any drains or tubes attached to you?			
Are you a diabetic? Is your diabetes well controlled? Do you take short acting insulin? Do you take long acting insulin? Do you have a thyroid problem now or in the past?			
Are you on Steroid tablet medication (e.g Prednisolone) or antibiotics? If yes, please inform us as to why and how long you are on them, as this may affect your appointment.			
Do you suffer from Epilepsy?			
Do you have episodes of incontinence?			
What is your approximate weight and height?			
FEMALES			
Could you be pregnant? What was your last menstrual cycle date?			
Are you breastfeeding?			

PLEASE NOTE : In-patients must <u>not</u> be on TPN or Dextrose IV Infusions on the morning of scan.
PLEASE FAX COMPLETED FORM TO PET/CT, ST. JAMES'S HOSPITAL @ 01 4284137

I have read and understand the questions on this consent form and agree to be imaged.

Signature _____**Witness** _____**Date** _____

If any queries please contact the PET/CT Secretary @ Tel - 01 428 4947
Fax- 01 428 4137
Email – PetCT@stjames.ie