

Procedure Assessment Form (PAF)

Last Name		First Name		Middle Initial
Date of Birth	Sex	Weight _____ lbs.	Height _____ ft _____ in.	
Circle one: Adult Pediatric Phantom Other _____				
Subject ID:		Scan ID :		
Dictation Requested (circle): NO YES		Registration# (Call 362-7111, opt #2):		
MRN#	ACC#:	CPT Code:		
PI NAME/Pager:		COORDINATOR NAME/Pager:		
Ordering MD:		Diagnosis:		

Research / SOC: (Mark one below)	Modality (EPIC scanner IDs)
---	------------------------------------

<input type="checkbox"/> Research WITHOUT Epic <input type="checkbox"/> Research WITH Epic <input type="checkbox"/> Standard of Care <input type="checkbox"/> SOC + _____ min Research	<input type="checkbox"/> Biograph PET-CT <input type="checkbox"/> VISION PET-CT <input type="checkbox"/> PET-CT <input type="checkbox"/> CT Only <input type="checkbox"/> 3.0T Prisma MRI (CIRMR2) <input type="checkbox"/> 3.0T VIDA MRI (CIRMR1)	<input type="checkbox"/> Siemens Biograph mMR (PET/MR) <input type="checkbox"/> Dual mode (CIR3PT) <input type="checkbox"/> Single mode (Mark one below) <input type="checkbox"/> PET Only <input type="checkbox"/> MRI Only (CIRPT2) (CIR3T)
---	--	--

START TIME:	END TIME:
--------------------	------------------

Additional Resources

Invasive procedure/tests <input type="checkbox"/> IV: _____ g angio Location: _____ <input type="checkbox"/> i-stat= _____ mg/dl @ _____ <input type="checkbox"/> Creatinine= _____ mg/dl Date: _____ <input type="checkbox"/> eGFR= _____ <input type="checkbox"/> Glucose= _____ mg/dl @ _____ <input type="checkbox"/> HCG= _____ @ _____ N/A Lot#: _____ <input type="checkbox"/> Other: _____ _____ <input type="checkbox"/> Parking <input type="checkbox"/> Valet <input type="checkbox"/> N/A	Injection/Medication <input type="checkbox"/> Contrast: _____ cc (circle) • Dotarem Multihance • Other: _____ <div style="background-color: yellow; padding: 2px;">Time of injection: _____</div> <input type="checkbox"/> RaPh tracer: _____ <input type="checkbox"/> Receive/return package (tech): _____	Other Services <input type="checkbox"/> Nursing: _____ <input type="checkbox"/> Technologist: _____ <input type="checkbox"/> ftp _____ : _____ <input type="checkbox"/> Room: _____ <input type="checkbox"/> Data transfer: EPIC: _____ <div style="color: red;">CNDA images: _____</div>
--	---	---

Technologist Check List and Comments

Docs with ALL Scans: _____ Consent _____ Med/Allergy List _____ HCG / N/A

Docs with MRI Scans: _____ MRI Screen / N/A _____ Creat/GFR checked/ N/A

_____ Contrast Info: Received - Refused - In-Patient - N/A

Docs with PET scans: _____ PETDoc Sign - N/A _____ QC - N/A

Technologist Signature:	Date:
Name:	