Print Form

# ABDOMINAL NUCLEAR MEDICINE WORKSHEET

Name_____ X-ray #_____ Date_____

Please describe the special problem or symptom that led to this exam:

_____
_____
_____
_____

**Biliary Scan/ Biliary EF**

| | | |
|---|---|---|
| Pain | ☐ yes | ☐ no |
| Nausea/Vomiting | ☐ yes | ☐ no |
| Fever | ☐ yes | ☐ no |
| Weight Loss | ☐ yes | ☐ no |
| Diarrhea | ☐ yes | ☐ no |
| Previous Surgery | ☐ yes | ☐ no |
| Previous Exam | ☐ yes | ☐ no |

RUQ LUQ RLQ LLQ
Right Flank Left Flank
Epigastric Other_____

**Liver /Spleen Scan**

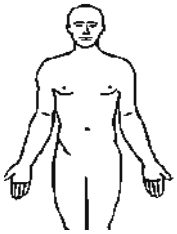
| | | |
|---|---|---|
| Jaundice | ☐ yes | ☐ no |
| Liver Trouble | ☐ yes | ☐ no |
| Hepatitis | ☐ yes | ☐ no |
| Rapid Weight Loss | ☐ yes | ☐ no |
| Gallbladder Removed | ☐ yes | ☐ no |
| Radiation Therapy | ☐ yes | ☐ no |
| Ever Had Chemotherapy | ☐ yes | ☐ no |
| Previous Surgery | ☐ yes | ☐ no |

**Renal Scan**

| | | |
|---|---|---|
| Hypertension | ☐ yes | ☐ no |
| Pain | ☐ yes | ☐ no |
| Nausea/Vomiting | ☐ yes | ☐ no |
| Fever | ☐ yes | ☐ no |
| Weight Loss | ☐ yes | ☐ no |
| Diarrhea | ☐ yes | ☐ no |
| Previous Surgery | ☐ yes | ☐ no |
| Previous Exam | ☐ yes | ☐ no |
| History of Cancer | ☐ yes | ☐ no |

**Lab Data**

BUN_____
Creatinine_____



Injected by:
☐ J Simonds ☐ S Hadlick
☐ P Peguero ☐ S Marcello
☐ D Komor
☐ Other

Consent given by Parent /guardian for minor to have nuclear medicine procedure:
Name:_____ Date:_____