



8501 Wade Blvd
Suite 220
Frisco, Texas 75034
Tel: 214-618-3420
Fax: 214-618-3450

DISCOGRAM INSTRUCTIONS

Pre- Procedure:

- 1. No pain medication 6 hours prior to the exam time. Patients must be off anticoagulants 7 days prior to procedure. Contact your physician if you have any questions regarding your medication.**
- 2. No solid foods 6 hours prior to appointment time. You may continue clear fluids 4 hours prior to appointment time. You may take your usual medications with sips of water the day of the procedure except those listed above.**
- 3. *Please arrive 1 hour prior to scheduled exam time.* This is necessary to fill out paperwork, complete nursing assessment, go over how the procedure is performed, and sign consent form.**
- 4. You must have a driver who can pick you up and take you home. If you do not have anyone available on the day of your procedure, please call and reschedule (972-954-8001)**
- 5. *Patients must bring previous MRI / CT exams and associated reports with them on the day of the procedure.***

Post-Procedure:

You can anticipate a post-procedure stay of approximately 2 hours. You will be encouraged to relax and lie in bed for 24 hours after the procedure. Plan on missing work the day of and the day after the procedure.

****Allergies: If you have a known allergy to Iodine, please consult your physician for pre-treatment.**



CT/RADIOLOGY CLINICAL AND CONTRAST HISTORY

PATIENT HISTORY

Please check the appropriate answer.

Are you diabetic? Yes _____ No _____

If yes, you must check with your doctor BEFORE having an IVP or CT. Glucophaga, Metformin, Glucovance, Avandamet, Metaglip, Fortamet, Riomet or ActosPlus Met may be taken up to and including the day of the exam. You may restart 48 hrs. later, but not until your renal functions have been tested.

Have you had any previous surgery on your kidneys, ureters, or bladder? Yes _____ No _____

If yes, please describe: _____

Have you had any history of kidney problems? Yes _____ No _____

If yes please describe: _____

Have you ever had an allergic reaction to Iodine Contrast? Yes _____ No _____ If so please

Describe: _____

Do you have a history of the following:

Drug/food allergy: Yes ____ No ____

Hives: Yes ____ No ____

Hay fever: Yes ____ No ____

Asthma: Yes ____ No ____

Heart Disease: Yes ____ No ____

Sickle Cell Disease: Yes ____ No ____

Multiple Myeloma: Yes ____ No ____

Seizures: Yes ____ No ____

Most patients experience no unusual effects from this injection. As with any procedure, however, a few risks are involved. During the injection, you may experience a warm sensation, nausea or vomiting. A few patients have an allergic type reaction with itching and hives (raised skin reactions resembling mosquito bites), swelling of the eyes and lips, sneezing, or difficulty in breathing. Medications are on hand to treat these conditions should they occur. In rare instances, more serious complications are encountered. These complications may include shock, kidney failure, and cardiac arrest. We have facilities to treat these reactions immediately. However, the risk of life-threatening reaction is extremely low (approximately 1 in 150,000 people). We will be happy to answer any specific questions you may have about the procedure, either before or at the time of the study.

I understand the procedure and give permission for the intravenous injection of contrast material.

Patient/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

TO BE COMPLETED BY DEPARTMENTAL STAFF

EXAM: _____ **DX:** _____

CONTRAST TYPE: OPTIRAY 320 **AMOUNT:** _____

INJECTION SITE INFORMATION:

ANGIOCATH:

BUTTERFLY:

INJECTION SITE:

_____ 18 ga

_____ 19 ga

_____ WRIST R__ L__

_____ 20 ga

_____ 21 ga

_____ ANTECUBITAL R__ L__

_____ 22 ga

_____ HAND R__ L__

_____ FOREARM R__ L__

TECHNOLOGIST: _____ **DATE:** _____

RADIOLOGIST: _____ **DATE:** _____

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Date: _____

PATIENT INFORMATION

Name: _____ # _____
Last First Middle Social Security Number

Date of Birth: _____ Sex: _____ Circle one: Single Married Divorced Widowed

Home Address: _____
Street City State Zip

Home Phone: _____ Occupation: _____

Employer: _____ Work Phone: _____

Work Address: _____
Street City State Zip

Allergies: _____

Current Prescriptions: _____

Medical Conditions: _____

PRIMARY INSURANCE HOLDER

Circle One: Self Spouse Parent Other Date of Birth: _____ Sex: _____

Name: _____ # _____
Last First Middle Social Security

Address: _____
Street City State Zip

Employer: _____ Occupation: _____

Work Address: _____

Home Phone: _____ Work Phone: _____

I understand that I am financially responsible for all charges, and that payment is expected at the time of service.

X _____
(signature)

I hereby authorize the physician to furnish information to insurance carriers concerning this and other subsequent visits.

X _____
(signature)



Patient Name: _____

Date: _____

Feel free to ask any questions you may have at the time of your exam.

Try to be specific and use as many dates as you can.

Date Symptoms started or Date of incident:

Symptoms &/or Change in symptoms:

Recent Treatments/Medications used? Are they relieving your symptoms?

Past Injuries to Area:

Do You Have a History of Cancer?

Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? Yes No

If yes, please indicate the date and type of surgery:

Date: _____ Type of Surgery: _____
Mo. Day Yr.

Date: _____ Type of Surgery: _____
Mo. Day Yr.

Do you have a follow up appointment scheduled with your doctor?

Yes No

If yes, Date: _____ Time: _____



Patient Signature Form

Verification of Document Receipt
Privacy Notice and
Patients Rights and Responsibilities

I have been given the opportunity to read a copy of the "Privacy Notice" and "Patient Rights and Responsibilities." I understand that if I have any questions regarding these documents I may call NORTH STAR DIAGNOSTIC IMAGING at 214-618-3420 or 972-954-8001 for additional explanation.

Signature of Patient or Guardian: _____ **Date:** _____

Assignment of Insurance Benefits and Release of Information for Billing Purposes

I, the undersigned, have insurance coverage with _____ and assign directly to NORTH STAR DIAGNOSTIC IMAGING, SOUTHWEST IMAGING AND INTERVENTIONAL SPECIALIST AND/OR NORTH TEXAS RADIOLOGY all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.

I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Patient or Guardian: _____ **Date:** _____

Patient Request of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted at the following number: _____

Please circle all that apply:

OK to leave message with detailed information

Leave message with call-back number only

Signature: _____ **Date:** _____

NORTH STAR STAFF SIGNATURE: _____ **Date:** _____