

DATE: _____

CCIR#: _____ HRPO#: _____ mMRD# / MRD# : _____

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#		
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"/> WANDA VISION PET-CT <input type="checkbox"/> Siemens Biograph mMR (PET/MR) <input type="checkbox"/> VISION PET-CT <input type="checkbox"/> Dual mode (CIR3PT) <input type="checkbox"/> PET-CT (BJH CIRPCT) <input type="checkbox"/> Single mode (Mark one below) <input type="checkbox"/> CT Only (BJH CIRCT) <input type="checkbox"/> PET Only (CIRPT) <input type="checkbox"/> 3.0T Prisma MRI (CIRMR2) <input type="checkbox"/> MRI Only (CIR3T) <input type="checkbox"/> 3.0T VIDA MRI (CIRMR1)		
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) <input type="checkbox"/> Dotarem Multihance <input type="checkbox"/> Other: _____ Time of injection: _____ <input type="checkbox"/> RaPh tracer: <i>Approved Dose:</i> _____ mCi @ _____ <input type="checkbox"/> Receive/return package (tech): _____		Other Services <input type="checkbox"/> Nursing/Technologist _____ <input type="checkbox"/> ftp _____ : _____ <input type="checkbox"/> Room: _____ <input type="checkbox"/> Data transfer: EPIC: _____ CNDA images: _____
Technologist Check List and Comments				
Docs with ALL Scans: _____ Consent _____ Med/Allergy List _____ HCG / N/A Docs with MRI/CT Scans: _____ MRI Screen / N/A _____ CT Contrast Questionnaire / N/A _____ Contrast Info: Received - Refused - In-Patient - N/A _____ Creat/GFR checked/ N/A Docs with PET scans: _____ PETDoc Sign - N/A _____ QC - N/A Check List: EPIC * ORDER * PRECERT * MRI PROTOCOL * ASSOCIATE STUDY				
Technologist Signature: Name: _____ Date: _____				