

# Cancer Centers of NC – History/Order/Requisition – Combined Form (09/11/09)

**PATIENT INFORMATION**

PATIENT: \_\_\_\_\_ MR #: \_\_\_\_\_  
 DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ WT: \_\_\_\_\_ HT: \_\_\_\_\_ REX Patient ID #: \_\_\_\_\_  
 Examination: \_\_\_\_\_ Ordering MD: \_\_\_\_\_

**CLINICAL HX**

List known allergies: \_\_\_\_\_

Does patient have:	Sickle cell anemia	No	Yes	Angina Pectoris	No	Yes	
	History of kidney disease/renal failure	No	Yes	Pheochromocytoma	No	Yes	
	Multiple Myeloma	No	Yes	Amyloidosis		No	Yes
	Heart Attack past 8 weeks	No	Yes	Asthma	No	Yes	
	Unstable Angina	No	Yes	Cardiac Dysrhythmia	No	Yes	
	Valvular Heart Disease	No	Yes	PREGNANT?	No	Yes	
				Date of LMP?			

Diabetic: No Yes List diabetic meds: \_\_\_\_\_  
 Cardiac Meds: No Yes List cardiac meds: \_\_\_\_\_  
 Recent Surgery: \_\_\_\_\_  
 History of Contrast Reaction? No Yes Describe: \_\_\_\_\_  
 Was treatment necessary? \_\_\_\_\_

Radiation Therapy: No Yes Still receiving? No Yes Last Treatment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Chemotherapy: No Yes Still receiving? No Yes Last Treatment Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Do you have a Power Port? No Yes If yes, please bring your ID card with you to your scan appointment

**INFORMED CONSENT FOR IV INJECTION OF CONTRAST MEDIA:**

Your physician has requested this exam to obtain diagnostic information. It requires the injection of a contrast material (x-ray dye) into your vein. Complications resulting from the injection of the contrast are infrequent and can include, but are not limited to, nausea, vomiting, or hives or rash and rarely, kidney failure or death. Most patients report only a general body warmth or strange taste during the actual injection.

I, the undersigned, to the best of my knowledge, answered the questions listed above accurately and truthfully. I voluntarily consent to this examination and have been informed of the possible complications.

\_\_\_\_\_  
 Patient Signature Date Witness

**INSURANCE AUTHORIZATION:** Primary Insurance: \_\_\_\_\_ Secondary: \_\_\_\_\_  
 Authorization #: \_\_\_\_\_ Verified by: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Has your insurance changed within the past 60 days? No Yes

Interpreting Radiology Group: Raleigh Radiology RESEARCH PATIENT – DO NOT BILL (scan covered by study)

I understand that the procedure listed on this document will be interpreted by a radiologist at Raleigh Radiology, LLC., and that I will receive a separate bill for the interpretation of this procedure from Raleigh Radiology, LLC. I authorize Raleigh Radiology, LLC, to release any medical information or other information needed for this or any other related claim. I permit a copy of this authorization to be used in place of the original. If assignment is accepted, I request payment of insurance benefits be made directly to Raleigh Radiology, LLC. I am responsible to the deductible, co-payment, and non-covered service (as determined by the insurer). This consent and authorization pertains to the procedure(s) listed on this document and authorizes release to insurance company and physician listed on this document only.

\_\_\_\_\_  
 Patient or responsible party Date

Contrast Information: Omnipaque 300 350 Volume: \_\_\_\_\_ ml Lot#: \_\_\_\_\_ Exp. Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Describe Complications: Infiltration – describe \_\_\_\_\_

Reaction – describe \_\_\_\_\_

Assessment completed by: \_\_\_\_\_  
 \_\_\_\_\_