ENVISION
MEDICAL IMAGING

# Bone Scan Checklist

| Name | | |
|---|---|---|
| Date of birth | Weight *(kg)* | Height *(cm)* |
| Telephone *(hm)* | *(mob)* | *(wk)* |
| Contact in case of emergency | | |
| When is the next appointment with your Doctor? | | |

**Please circle your response and answer all questions on *both* sides of this page.**

| | | |
|---|---|---|
| Why has your doctor sent you for this scan? | | |
| Have you had a bone scan before? | YES | NO |
| *If **YES**, when and where?* | *Which body part?* | |
| Have you brought in previous X-rays, CT, or MRI scans? | YES | NO |
| Are you having any other additional radiology or pathology procedures done today? | YES | NO |
| *If **YES**, please describe* | | |
| Has your doctor diagnosed you with any of the following? | | |
| - *Osteoarthritis* | YES | NO |
| - *Rheumatoid arthritis* | YES | NO |
| - *Other (please describe)* | YES | NO |
| How long have you had the pain? | | |
| Can you please describe what caused the pain? | | |
| Do you have pain elsewhere? | YES | NO |
| *If **YES**, please describe* | | |
| Have you had any previous bone injuries or fractures? | YES | NO |
| *If **YES**, please describe* | | |
| Have you had any recent falls? | YES | NO |
| *If **YES**, please describe* | | |
| Have you had any previous major surgery? *eg. cardiac, mastectomy, back surgery, etc.* | YES | NO |
| *If **YES**, please describe* | | |

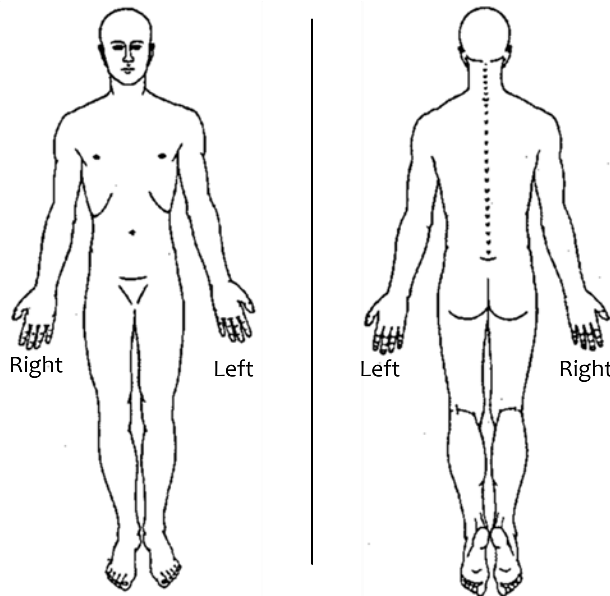
**PTO**

ENVISION MEDICAL IMAGING

# Bone Scan Checklist

| Do you have, or have you ever had any type of cancer? | YES NO |
|---|---|
| *If **YES**, please describe* | |
| Are you taking any medication related to your current condition? | YES NO |
| *If **YES**, please describe* | |
| Have you ever had any joint injections? | YES NO |
| *If **YES**, please describe* | |
| Is there any chance you may be pregnant? | YES NO |
| Are you breastfeeding? | YES NO |

Please highlight the areas that are painful *(if relevant)* on the diagram below




**I have read this form, understand the purpose and the risks of the tests, and consent to the tests being performed.**

| Patient Name | | |
|---|---|---|
| Patient Signature *(or signature of legal guardian)* | | Date |
| Signature of MIT / Radiologist | | |

**OFFICE USE ONLY**

**ANTICOAGULANTS** ☐ Yes ☐ No **DIABETIC** ☐ Yes ☐ No **ALLERGIES** ☐ Yes ☐ No **DRIVER** ☐ Yes ☐ No

Envision Medical Imaging Suite 5, 178 Cambridge Street *(opp. SJOG Hospital, Subiaco)* T 08 6382 3888 F 08 6382 3800

VERSION 2.0 JULY 2010 APPROVED BY CLINICAL MANAGEMENT GROUP