OCMRI
MRI-PET-CT
17150 Euclid Street, Suite 101
Fountain Valley, CA 92708
(714) 957-0317 Fax (714) 957-0616

FLUORIDE 18 BONE SCAN

DATE: _____

PATIENT NAME: _____ _____ CHART NO:_____
LAST **FIRST**

AGE: _____ **BIRTH DATE:** _____ **SEX:** M / F

HEIGHT: _____ **WEIGHT:** _____

REFERRING PHYSICIAN: _____ PHONE: _____

- WHAT IS THE **REASON** YOUR DOCTOR **ORDERED** THIS **BONE** SCAN?

  _____

- DO YOU HAVE A **HISTORY OF CANCER?** IF SO, WHAT TYPE?

  _____

- HAVE YOU HAD A PREVIOUS **BONE SCAN?** Y / N
  IF YES, WHERE AND WHEN? _____

- HAVE YOU HAD **CHEMOTHERAPY OR RADIATION TREATMENT?** Y / N
  IF YES, START AND END DATE: _____

FOR TECHNOLOGIST ONLY

DOSE ADMINISTERED: _____ mCi

_____mCi @ _____

INJ. _____@ _____

POST _____mCi @ _____

_____ ml

PATIENT INFORMATION SHEET

OCMRI
MRI-PET-CT

Chart No. _____

Scan _____

Insurance _____

Date and Time of Appointment: _____

PATIENT INFORMATION

Patient Name: _____ Driver's License No. _____

Address: _____

City, State Zip: _____ Date of Birth: _____

Telephone (Home): _____ Telephone (Work): _____

Social Security Number: _____

Emergency Contact Name _____ Telephone _____

REFERRING SOURCE

Doctor: _____ Chiropractor: _____ Other: _____

Name of Referring Source: _____ Telephone: _____

INSURANCE INFORMATION

Subscriber Name_____ Subscriber SS#:_____

Relation to Patient_____ Policy No._____

Primary Ins_____ **Second Ins**_____

Group No._____ Group No._____

Member No._____ Member No._____

Address_____ Address_____

_____ _____

I authorize payment of medical benefits to Orange County MRI for medical services

Signature: _____

I also authorize release of medical information to process any claims

Signature: _____ Date: _____