



One Life. One Scan. Life Scan.

LifeScan Imaging of Michigan
11012 Thirteen Mile Road Suite 111
Warren, Michigan 48093
Phone: (586) 558-8470 Fax (586) 558-8470

Dear Patient:

This letter is to inform you of our policy at LifeScan Imaging of Michigan. We do not routinely film any CT studies done at this facility, unless the ordering physician requests films.

We offer a CD Rom that provides copies of your CT Scan images for a cost of \$10.00, that is yours to keep and/or share with other physician.

Sorry for any inconvenience in this matter.

Date: _____

Patient Signature _____

LIFE SCAN IMAGING CORPORATION

11012 THIRTEEN MILE ROAD, SUITE 111

WARREN, MI 48093

(586) 558-8470 FAX: (586) 558-8481

PREGNANCY WAIVER FOR CT, X-RAYS AND OR FLUOROSCOPY

I, _____ HEREBY STATE THAT AS OF TODAY
(PATIENT NAME)

_____, I AM NOT PREGNANT AND AGREE TO HAVE CT SCAN,
(DATE)

**XRAYS AND OR FLUOROSCOPY TAKEN. SHOULD IT BE DETERMINED THAT I
AM PREGNANT, I WILL NOT HOLD LIFE SCAN IMAGING CORPORATION,
PHYSICIANS OR STAFF RESPONSIBLE FOR ANY DAMAGES TO ME OR THE
FETUS.**

DATE OF LMP: _____

DATE: _____

PATIENT SIGNATURE: _____

PARENT/GUARDIAN SIGNATURE (IF MINOR): _____

WITNESS SIGNATURE: _____



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11012 Thirteen Mile Road Suite 111
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Phone: (586)558-8470 Fax: (586) 558-8481

Date: _____

Patient Name: _____

Type of Exam: _____

Referring Physician: _____

CT with Injection

You are scheduled to have an exam that requires an IV (intravenous) Contrast Injection. Due to insurance requirements, we at LifeScan will need additional information. Please fill out the information below. Our technologist will review the form with you and answer any questions you may have about the questions or your answers.

A Cat Scan (CT) has been requested by your doctor. The routine procedure takes approximately 30 minutes. It involves the injection of contrast followed by a series of x-rays. As with any procedure, there are potential risks. They range from minor to major such as: contrast induced rash, nausea/vomiting, itching, difficulty breathing and on very rare occasion fatality.

Are you Diabetic? _____ Yes _____ No _____ If yes what medications are you taking? _____

Date of your most recent blood draw? _____

I, _____, give permission to LifeScan to perform a Cat Scan (CT) in this office today. I have read and understand the above article on the procedure I am having done today. Reactions and complications have also been explained to me and I give my consent as a patient /guardian.

Patient Signature: _____ Date: _____

Technologist Signature: _____

PLEASE PRINT CLEARLY & COMPLETE FULLY

Date _____ Patient # _____ Doctor _____

Patient Last Name _____ First Name _____ M.I. _____

Address _____ Apt. # _____ City _____ State _____ Zip _____

Birth Date _____ Age _____ Sex _____ Social Security # _____

Home Phone () _____ Cell Phone () _____ Work Phone () _____

Emergency Phone () _____ Check one: Married _____ Single _____ Divorced _____ Widowed _____

Is the patient being treated for HIV, AIDS or AIDS RELATED disease? Yes _____ No _____ Hepatitis? Yes _____ No _____

Employer _____ Occupation _____

Address _____ City _____ State _____ Zip _____

How long with this employer? _____ Missed any work? _____ Last date worked _____

REFERRING PHYSICIAN

FAMILY PHYSICIAN

Name _____ Name _____

Address _____ Address _____

City _____ City _____

State & Zip _____ State & Zip _____

Phone () _____ Phone () _____

Patient's Relationship to the Insured Party: Self () Spouse () Dependent () Other ()

This problem is related to which of the following: Employment () Auto Accident () Other ()

CHECK ONLY ONE: This problem is an injury: Yes () No () This problem is something that has developed: Yes () No ()

Insured Policy Holder's Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Insured's Home Phone () _____ Work Phone () _____

Insured's Social Security # _____ Insured's Employer _____

Date of injury or date problem first noticed _____ Patient's Dominant Hand: Right () Left ()

Injured Hand/Fingers: Right () Left () Injured Arm/Elbow: Right () Left () Injured Wrist: Right () Left ()

List any medications you are taking _____

List any medications to which you are allergic _____

Problem & complaints: _____

PLEASE RETURN THIS FORM WITH INSURANCE CARDS,
DRIVER'S LICENSE, AND ANY AUTHORIZATIONS

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PATIENT NAME: _____ DATE: _____

AGE: _____ WEIGHT: _____ HEIGHT: _____ SEX: _____ Male _____ Female

REASON FOR CT EXAMINATION: _____

Previous CT? _____ Yes _____ No Date: _____ Location: _____

Of what regions of your body? _____

Previous x-ray of your: (please circle all that apply) Chest Abdomen Pelvis
Date: _____ Location: _____

Previous Ultrasound? _____ Yes _____ No Results: _____

Past surgical operations and dates: _____

Chest: _____ Abdomen: _____ Gallbladder: _____ Appendix: _____ Pelvic: _____

Transurethral Prostatectomy (TURP): _____ Hysterectomy: _____ Complete: _____

Cancer of _____ Diagnosed when? _____

Treatment & dates: Chemo _____ Radiation _____ Surgery _____

Has it metastasized (spread distantly or locally invaded)? _____

If you are a female, Are you pregnant? _____ Yes _____ No Date of LMP: _____

Are you currently taking any medications? Yes _____ No _____ (If yes, please list medications) _____

Do you smoke? _____ Yes _____ No # of packs per day _____ for _____ years

Do you have a history of allergies to any of the following items? (please circle) Fish Iodine IV Contrast

Medications: yes _____ no _____ (If yes, please list) _____

Other Allergies: yes _____ no _____ (If yes, please list) _____

Do you have current or past history of the following medical conditions? (Please circle all that apply)

Heart Disease Diabetes Asthma Stroke Sickle Cell Disease

Current Apprehension (Feeling Anxious) Current Dehydration or Vomiting Lung Disease (COPD)

Renal Insufficiency (Kidney Disease, Abnormal BUN/Creatinine levels) Claustrophobic Difficulty Lying Flat

History of Previous Contrast Media Injections Hypertension (High Blood Pressure)

Other conditions you believe we should know about: _____

For technologist use:

Clinical information in addition to the provided history: _____

Technologist's Comments: _____

Patient unable to tolerate or adverse reaction to contrast: _____

Technologist's Signature: _____ Date: _____