CEDARS-SINAI®

S. MARK TAPER FOUNDATION
IMAGING CENTER

RENAL SCAN QUESTIONNAIRE

PATIENT I.D.

********* Please drink 8 ounces of water while waiting for the exam to begin. *********

1: **What is the reason for this test?:** (*Please check all that apply)*

- ☐ Chronic Kidney *(Renal)* Failure
- ☐ Acute Kidney *(Renal)* Failure
- ☐ Prior Episode of Renal Failure When: ________________
- ☐ Prior Kidney transplant *(Anterior imaging)*
- ☐ Liver failure
- ☐ Potential kidney donor
- ☐ Kidney Trauma / Injury
- ☐ Kidney Stones
- ☐ Kidney obstruction *(hydronephrosis)*
- ☐ Diabetic
- ☐ Hypertension Most recent Blood Pressure: ________________
- ☐ Heart Failure
- ☐ Other: ________________

2. **Please describe your symptoms:** (*Please check all that apply)*

- ☐ None
- ☐ Pain
- ☐ Blood in the urine

3. **Please tell us about prior kidney surgery or procedures:** (*Please check all that apply)*

- ☐ No prior surgery or procedures to the kidneys
- ☐ Stent
- ☐ Kidney removed
- ☐ Bladder removed
- ☐ Kidney stone removed

Height: _______________

Weight: _______________

Technologist Initials: __________

NAME OF PATIENT (please print)	SIGNATURE OF PATIENT	DATE	TIME
NAME OF TECHNOLOGIST (please print)	SIGNATURE OF TECHNOLOGIST	DATE	TIME

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This page is to be completed by Nuclear Medicine Technologist or Registered Nurse.

1. Check for special indications:
   - ☐ Reno Vascular Hypertension *(Pre test Captopril may be required)*
   - ☐ Hydronephrosis *(Diuretic may be required)*
   - ☐ Vesico- ureteric reflux

2. Serum Creatinine Level: __________ mg / dL

3. Details of prior Procedures / Surgery:
   - ☐ Transplant When: __________ Where: __________
     Is transplanted kidney from a living donor? ☐ Yes ☐ No
     Did family member donate? ☐ Yes ☐ No
   - ☐ Renal artery Angioplasty When: __________ Where: __________
   - ☐ Urethral Stent Placement When: __________ Where: __________
   - ☐ Prior Nephrectomy
   - ☐ Prior Cystectomy
   - ☐ Nephrostomy? *(specify side, and whether tube is open or occluded during imaging)*

4. Prior Renal Imaging Studies: *(Please check all that apply)*
   - ☐ Ultrasound When: __________ Where: __________
   - ☐ CT When: __________ Where: __________

5. Is the patient taking any of the following medications?:
   Ace Inhibitors *(lotensin, vasotec, accupril, monopril, capoten, altace, prinivil)*
   Angiotensin II Receptor Blockers *(atacand, toventen, avapro, cozar, micardis, benicar, diovan)*
   Diuretic *(lasix, diazide, hydrochlorthiazide)*

6. Does the patient have a foley catheter inserted right now? *(Circle one)* ☐ Yes ☐ No

Additional Information:

____

____

____

____

NAME OF NUCLEAR MEDICINE TECHNOLOGIST (please print)	SIGNATURE OF NUCLEAR MEDICINE TECHNOLOGIST	DATE	TIME
NAME OF REGISTERED NURSE (please print)	SIGNATURE OF REGISTERED NURSE	DATE	TIME

(Dose Sticker Here)

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This page for Captopril Renal Scans Only

[Captopril and Isotope Dose Stickers Here]

Captopril Dose Administered: _______ mg
Time of Captopril Administration: ____________________
Captopril administered by: _________________________, RN

	Time	Blood Pressure Reading
Baseline		
15 minutes post-Captopril		
30 minutes post-Captopril		
45 minutes post-Captopril		
60 minutes post-Captopril		

NAME OF TECHNOLOGIST (please print)	TITLE	SIGNATURE OF TECHNOLOGIST	DATE	TIME