CERESCAN

Phone: (866) 722-4806
Fax: (833) 299-2501
Email: pcc@cerescan.com
www.CereScan.com

Patient Name: _____
Date of Birth: _____

PATIENT INFORMATION (please print)

Last Name:	**First Name:**	**M.I.:**
Phone: *Text message appointment reminders sent here*	**Email:**	
Mailing Address:		
City:	**State:**	**Zip:**
Date of Birth:	**Age:**	**Marital Status:**
Sex: Male ☐ Female ☐	**Weight:** lbs.	**Height:** ft. in.
If female: Are you pregnant, nursing or is there a chance you may be pregnant? Yes ☐ No ☐		
Racial/ethnic group you identify with:		**Handedness:** Right ☐ Left ☐

RESPONSIBLE PARTY (if patient is a dependent)

Name:	**Phone Number:**

EMERGENCY CONTACT (spouse, friend or relative who can be reached in case of emergency)

Full Name:	**Relationship to Patient:**
Address:	**Phone:**

INSURANCE INFORMATION

Insurance Carrier:	**Policy Number:**
Phone Number of Insurance Carrier:	
Name of Primary Insured:	**DOB of Primary Insured:**
Address of Primary Insured (if different)**:**	

PATIENT CLINICAL INFORMATION

Primary reason(s) for brain scan:

ALLERGIES AND ADVERSE REACTIONS TO MEDICATIONS

Allergen	Type of Adverse Reaction/Symptoms

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CURRENT MEDICATIONS AND/OR SUPPLEMENTS *Please try to use the correct spelling. If you are unsure, write "?"*

Medication/Supplement Name	Dose	Schedule	Date Started

PRIVACY & SECURITY

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of protected health information (PHI) to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. NOTE: Uses and disclosures by the Privacy Officer may be permitted without prior consent in an emergency.

With Whom May We Share Your PHI? (Full Name)	Relationship to Patient

**If you are working with an attorney and would like us to disclose your results to them, please list their name above.*

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI. The individual is also provided the right to request confidential communication or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (if different from above):

☐ Phone: _____ ☐ Email: _____

How would you like your report delivered to you? ☐ Email ☐ Mail

When would you like to receive your report?

☐ Immediately upon completion ☐ At/during the imaging review session

I hereby authorize CereScan® to release to my Referring Physician a copy of my medical records. I understand and agree that all images and medical records generated for and on my behalf will become part of CereScan®'s expanding proprietary database for ongoing scientific research into neurological and neurobehavioral disorders. I hereby authorize CereScan® to use and replicate all medical information contained in the images and reports for proprietary research, training, teaching or other purposes deemed appropriate by CereScan®. In order to protect my identity, I understand that all identifying information will be removed from all images and reports prior to its use.

I understand my results will be sent to me and my referring doctor, and I will have the opportunity to review my images, diagnostic findings and impressions in a follow up post imaging review session. I also understand that CereScan® is a diagnostic imaging facility and cannot provide treatment, management of care, case management services, medication protocols or prescribe medication. I further understand that CereScan® can consult with my referring provider regarding my imaging results but cannot implement a treatment plan. _____ **Initial**

Signature: _____ Name (Printed): _____ Date: _____

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PATIENT CLINICAL INFORMATION AND HISTORY

If female: Are you pregnant or planning to become pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Have you ever been diagnosed with any of the following conditions?

Kidney disease	☐ Yes	☐ No
Liver disease	☐ Yes	☐ No
Stroke	☐ Yes	☐ No
Huntington's disease	☐ Yes	☐ No
Wilson's disease	☐ Yes	☐ No
Pituitary adenoma	☐ Yes	☐ No

Have you previously had an imaging study (CT, Urogram) with iodine contrast? ☐ Yes ☐ No
If yes, when? _____
Are you allergic to iodine, DATscan, or Lugol's solution? Yes No
Please list any severe allergic reactions to medications or other substances below:
_____
_____

CERESCAN

CANCELLATION/MISSED APPOINTMENT FEE AGREEMENT

This Cancellation/Missed Appointment Fee Agreement ("Agreement") is made and entered into by and between CereHealth Corp. ("CereScan"), whose address is 991 Southpark Drive, Suite 200, Littleton, CO 80120, and _____("Responsible Party"), whose address is _____.

Responsible Party understands that he/she has scheduled an appointment with CereScan to obtain certain medical services. Responsible Party understands that CereScan will be required to make certain arrangements and purchase certain medical goods to prepare for his/her appointment, in advance of the visit. Responsible Party further understands that if he/she cancels or misses his/her appointment(s) or fails to comply with the stated imaging protocol, CereScan may incur costs that cannot be recovered.

In consideration of the medical imaging services to be performed by CereScan, Responsible Party agrees to pay two thousand, three hundred ($2,300.00) dollars ("Missed Appointment Fee") to CereScan if he/she cancels or misses any of the appointments or fails to comply with the stated imaging protocol, for any reason or no reason. **Responsible Party understands that he/she may cancel or reschedule appointment(s) by calling (720) 925-5071 at least 24 business hours (1 business day) before his/her schedule appointment(s), without being charged the Missed Appointment Fee.**

By signing this Agreement, Responsible Party understands the full amount of the Missed Appointment Fee that may be owed to CereScan, and accepts the terms and conditions of this Agreement. In the event that there are any problems with payment of the Missed Appointment Fee, Responsible Party understands that he/she may be subject to any fees incurred in collecting the account balance including, but not limited to, collection costs and legal fees.

Credit Card Visa ☐ MC ☐ Discover ☐ _____

Name on Card _____

Card Number _____

Expiration Date _____

CVC Code _____

Billing Street Address _____

Billing Zip Code _____

_____
Signature

_____
Name (printed) Date of Birth

_____
Date

DaTscan Patient Instructions and Information

IF YOU ARE ALLERGIC TO IODINE, PLEASE CONTACT YOUR PATIENT CARE COORDINATOR IMMEDIATELY!

IF YOU ARE PREGNANT, YOU MAY NOT HAVE THIS PROCEDURE. PLEASE LET YOUR CARE COORDINATOR KNOW IMMEDIATELY.

FLUID CONSUMPTION REQUIREMENTS:

- **Prior to the scan:** In the 24-hour period prior to your scan, you must drink 6-8 glasses (36-48 ounces) of water and continue to drink 6-8 glasses water per day for 48-hours (2 days) after your scan.
- **After the scan:** It will be necessary to increase your intake of fluids to aid the elimination of the radioisotope from your body. You will be provided discharge instructions.

MEDICATION RECOMMENDATIONS:

Below is a list of prescription and over the counter medications that should be discontinued prior to a DaTscan. These recommendations should be discussed with your doctor as there may be important instructions for weaning off them.

Prescription Medication Recommendations

These recommendations are based on the half-life of the medication. Please consult your referring provider.

- **Benztropine (Cogentin):** Discontinue **5** days prior to your scan
- **Bupropion (Wellbutrin, Zyban, Aplenzin):** Discontinue **8** days prior to your scan
- **Dexamphetamine (Dexadrine)**: Discontinue **7** days prior to your scan
- **L-DOPA:** Discontinue ONLY under the written order of a neurologist for **12** hours prior to your scan (must consult with neurologist)
- **Mazindol (Mazanor, Sonorex)**: Discontinue **3** days prior to your scan
- **Methylphenidate (Concerta**): Discontinue **2** days prior to your scan
- **Methylphenidate (Ritalin)**: Discontinue **1** day prior to your scan
- **Modafinil (Provigil)**: Discontinue **3** days prior to your scan
- **Phentermine (Adipex-P, AttiPlex P, Ionamin, Kraftobese, Duromine):** Discontinue **14** days prior to your scan

Over-the-Counter Medication Recommendations

Discontinue 1 day prior to your scan

- Ephedrine (má huáng, dietary supplements)
- Norephedrine (PPA, Accutrim)
- Phenylephrine
- Phenylpropanolamine (PPA, Accutrim)
- Pseudoephedrine (Sudafed)

Plan on the following schedule for your day:

- 9:30 AM: thyroid blocker
- 10:30 AM: injection
- 2:30 PM: DaTscan

Please wear comfortable clothing. After the injection, you are free to leave for 4 hours, and must return at 2:30 p.m. for the imaging. Timing for the scan is precise, and if you are late, we may not be able to proceed with the imaging.

Frequently Asked Questions

Are there any side effects or risks to the brain imaging study? Though rare, allergic reactions have been reported. For DaTscan, the reactions have generally consisted of skin erythema and pruritus (redness and itching). Failure to block thyroid uptake of iodine ^{123} may result in an increased long-term risk for thyroid cancer. Other adverse reactions reported consisted of headache, nausea, vertigo, dry mouth or dizziness. These reactions were of mild to moderate severity.

Will I feel pain when the radiopharmaceutical is injected? You will only feel a small pinch from the needle as it is placed into your vein.

How is the brain scan procedure done: After you have received the injection of the radiopharmaceutical and return to the clinic for your scan, you will meet again with the technologist. The technologist will have you lay down on the camera table, which is padded for your comfort. You may request that music be played in the room during the scan. Many patients find this helps the time go by more quickly. Once the scan begins, the detectors will slowly rotate around your head. They will come close to you but never touch you.

Will I be alone? No, the technologist will be nearby during the process.

Will the camera touch me? The camera will rotate around your head and shoulders, but no part of the machinery will touch your body. You will not go through a tube. The time on the camera table is approximately 40 minutes.

Can I move during the scan? No, you cannot move during the scan. Your head and body must remain motionless (blinking eyes and swallowing are okay) for approximately 40 minutes or the scan will be compromised and unreadable by our physicians. The camera table has a soft cushion and most patients find it quite comfortable.

After I've been injected with the radioisotope, should I avoid physical contact with others? No, that is not necessary unless you have an infant, in which case you should avoid prolonged contact for 72 hours. In general, the radioisotope you are given will remain in your body for a short period of time. It is eliminated by urination, thus drinking more fluids afterwards will aid this process. If you are traveling by airplane within 24 hours following a scan, please make sure to let the technologist know. If any special precautions are necessary, the technologist will advise you. If you are nursing, you will have already received and need to comply with the *Policies and Procedures for Patients who are Breast-feeding*.

Will I get a diagnosis from the brain scans? Your doctor will use the data from your DaTscan report to help form a conclusion about your condition or assign a diagnosis.

Can I resume normal activities after the scan? You may return to all normal activities after the scan (driving, work, school, exercise, etc.)

Call your Patient Care Coordinator with any questions or concerns.