McLaren Flint

Hyperthyroidism Treatment Worksheet

Name _____ Date _____

MRN_____ DOB _____

Referring Physician _____

Nuclear Radiologist _____

Indication for exam _____

Severity ____/10 Duration _____

Surgeries _____

Recent administration of iodine, thiourcil, cough meds etc.? ☐ Yes ☐ No

Recent administration of x-ray contrast media? ☐ Yes ☐ No

Hyperthyroidism symptoms/signs: ☐ Weight loss ☐ Nervousness ☐ Perspiration

☐ Heat Intolerance ☐ Tachycardia ☐Tremors ☐ Other

Hyperthyroid lab values: ☐ TSH ☐ T3 ☐ T4 ☐ FTI ☐ Other

24 hour thyroid uptake value:_____

Pregnancy test results: _____

Other Date:_____

_____

_____

Diagnosis of hyperthyroidism has been verified by clinical and lab data? ☐ **Yes** ☐ **No**

Procedure reviewed with patient and questions answered? ☐ Yes ☐ No

Consent form signed? ☐ Yes ☐ No

NA1131 dose Requested:_____

Reminder for dictation:

Always dictate that hyperthyroidism diagnosis has been verified by clinical / lab date, procedure has been completely reviewed with that patient, NA1131 dose verified and consent form signed.

Signature of Nuclear Radiologist: _____

PT.

MR.#/P.M.

DR.