



CARO REGION

BONE SCAN INFORMATION SHEET

PATIENT NAME: _____ Date: _____

X-RAY #: _____ DOB: _____ AGE: _____

PROCEDURE: _____

DIAGNOSIS: _____

ORDERING PHYSICIAN: _____

1. Reason for Exam: _____

2. Injury to affected area Yes _____ No _____ When _____

3. Other Imaging Modalities Performed
MRI _____ CT _____ Diagnostic _____

4. History of a) Diabetes _____ b) Cancer _____

5. History of; Hip Replacement: Rt _____ Lt _____
Knee Replacement: Rt _____ Lt _____

6. Comments or other pertinent information: _____

Isotope: Tc99m-MDP Dose: _____

Injection Time: _____ Technologist: _____