

NAME: _____ DATE: _____

MR# _____ DOB: _____ TECH: _____

INDICATION _____

SYMPTOMS _____

HX OF CANCER (DATE OF DX, CHEMO, RTX) _____

PRIOR EXAMS/STUDIES (WHEN & WHERE) _____

SURGICAL HX _____

OTHER MEDICAL HX (HTN, DM, CAD) _____

Ventilation _____ kcps

Perfusion – Ventilation = _____ Ratio

Perfusion _____ kcps

Ventilation

_____ mCiMAA = _____ mCiDTPA

Ratio

COMMENTS: _____

PHARMACY DOCUMENTATION:

