

Dear Patient,

You are about to undergo a scintigraphy.

With this method, radioactively marked material is administered into the body. This material will concentrate mainly in the target organ. Its emitted radiation may then be visualized by using a special camera.

At this point, we would like to explain the procedure and inform you about any potential risks.

Procedure

- You will be administered a slightly radioactive media (Technetium, Tc99m) into your vein. This medication will be excreted through urination and usually disappears completely from your body within 24 hours.
- Depending on the type of the scintigraphy, the exposure with the camera will be performed directly after the injection and/or after a waiting period of 2 to 4 hours. You do **not** have to stay in our institute for any waiting periods.

Please avoid longer contact to pregnant women or babies between the waiting periods. This examination is considered pain free.

After the examination

On the day of the examination, you should avoid longer contact to pregnant women or babies.

Nursing women should not breast-feed for a period of 48 hours.

You may pursue your usual activities after the exam.

On the day of the examination, you should drink lots of water and urinate frequently.

This helps washing out the substance and reduces radiation exposure as fast as possible.

Should you notice anything unusual until the following day of your examination, please contact us immediately.

Risks

- Radiation exposure: The exposure is roughly equivalent to 1.3 times of the natural annual radiation exposure within our environment.
- In case a contrast media needs to be used, it is in rare cases possible that an allergic reaction from your body occurs.
- If possible, this examination should be avoided in case of pregnant or nursing women.

To prevent this risk and other eventual contra-indications, we ask you to answer the safety questionnaire.

We are at your disposal for any further information.



Patient information –
Safety questionnaire
Nuclear medicine

Name : _____	Date of birth: <input style="width: 50px; height: 20px; border: 1px solid black;" type="text" value=" / "/>
First name: _____	Weight : <input style="width: 80px; height: 20px; border: 1px solid black;" type="text" value=" "/> kg
	Height : <input style="width: 80px; height: 20px; border: 1px solid black;" type="text" value=" "/> cm

	YES	NO
Do you take anticoagulants ? If yes : which : _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from any allergy or do you have asthma? If yes, which: _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from a kidney disease or kidney failure? If yes, which: _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a thyroid disease? If yes, what medication are you taking ? _____	<input type="checkbox"/>	<input type="checkbox"/>
Female patients only :		
Are you, or could you be, pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Are you breast feeding?	<input type="checkbox"/>	<input type="checkbox"/>
Remarks / additional information? _____ _____ _____ _____		
<p>By signing below, I confirm to have read the information about this exam and understood and correctly answered this questionnaire and give my consent to the conduct this exam. To better assess my case, I accept that Affidea can request previous reports or exams.</p>		
Signature of patient: _____	Date : <input style="width: 50px; height: 20px; border: 1px solid black;" type="text" value=" / "/>	