

FLUOROSCOPY EXAM PREPS

GI Series and/or Small Bowel Study - Nothing to eat or drink after midnight prior to the exam.

Barium Enema - The patient can pick up prep and instructions two days prior from participating facilities. The day before the exam remain on a clear liquid diet all day drinking 8 oz of water each hour. (For breakfast, lunch (noon) and dinner (5:00 pm) patient can drink sugar free drinks (no milk or creamer), clear broths, sugar free gelatin, sugar free popsicles.)

IVP / Kidney X-Ray - Avoid all dairy, greasy and fried foods the day before the exam. Do not have anything by mouth after midnight the night prior to the procedure.

HSG or HSS - Should be scheduled within 7-10 days of the first day of their last period. Refrain from intercourse on the same day of the procedure.

CT EXAM PREPS

CT Abdomen and Pelvis - Nothing to eat or drink 4 hours prior to exam. If oral contrast is needed for your exam, you will be notified.

CT Abdomen and Pelvis (Urogram) - Nothing to eat or drink 4 hours prior to exam. Oral contrast not given unless specifically indicated by provider.

CT Calcium Scoring - No caffeine or smoking 4 hours prior to exam.

CT Enterography - Nothing to eat or drink 4 hours prior to the exam. Once the patient arrives, they will be given Volumen contrast to drink at various intervals.

ULTRASOUND EXAM PREPS

Abdominal / RUQ Ultrasound / Liver Elastography - Nothing to eat or drink 8 hours before the exam.

Renal Artery Ultrasound - No food or drink 8 hours prior to the exam. Drink 24 oz. of water 30 minutes prior to the exam. Schedule preferably in the morning to eliminate bowel gas interference.

Renal Ultrasound - If under 1 year of age give formula breast milk or Pedialyte 30 minutes before exam (Please have parent give the amount of oz the infant would typically feed on during a feeding from bottle). If pt is 1-10 yrs. of age drink 8-10 oz of fluids 30 minutes before exam hold bladder if of age. 11yrs or older please start drinking 24oz of fluids at least 1 hour prior to exam and hold bladder, as bladder must be full for scan.

Pelvic / Early OB Ultrasound - Drink 32 ozs of fluid within 1 hour immediately preceding the exam time. Do not empty bladder; the bladder must be very full for this exam.

MAMMOGRAM EXAM PREPS

Do not wear deodorant or talcum powder the day of the exam.

BONE DENSITY (DEXA) PREPS

No calcium supplements for 24 hours prior to exam.

MRI EXAM PREPS

MRI of the Brain or Orbits - No eye makeup or hair pins/hair weaves

MRCP - No food or drink 4 hours prior to the exam.

MRI Enterography

- No food or drink 4 hours prior
- Arrive 90 minutes early to drink contrast
- Glucagon will be administered to relax bowel motion

MRI SCREENING QUESTIONS

Who is answering these questions? _____

What is your weight range? _____

Yes No

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had an MRI before? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a prior imaging pertaining to this order? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had an allergic reaction to MRI contrast? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever welded, worked with metal, or gotten any metal in your eye? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a pacemaker, defibrillator, deep brain stimulator, bladder stimulator, or tissue expanders in your breast? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a spinal cord stimulator? ***RR only performs scans on patients with Medtronic spinal cord stimulators. |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have an ear implant, brain aneurysm clip or coil, shunt, penile implant, artificial heart valve or stent, or IV filter? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have an artificial joint (knee, hip, etc.) or metal plates, rods or screws in your body? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have any metallic foreign objects in your body such as bullets, shrapnel, metal shavings, or BB's? This includes eye injuries including metal. |
| <input type="checkbox"/> | <input type="checkbox"/> | Is there any chance you could be pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a copper IUD? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had any surgery or an operation to your body? Please provide details regarding type and area of the body. |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have anything implanted in your body that you weren't born with? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you Claustrophobic? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use a walking device or need assistance with moving help such as getting up and down from the table so that we can ensure your safety during this visit? |

NUCLEAR MEDICINE PREPS

Meckels Scan - NPO minimum of 6 hours

Gastric Emptying - NPO minimum of 6 hours. If you take Reglan, Tegaserod, Domperidone and Erythromycin - stop 2 days prior to study. No antispasmodic medications 48 hours prior to the scan.

HIDA Scan - NPO minimum 6 hours. No morphine and morphine derivatives at least 6 hours before study.

BREAST MRI SCREENING QUESTIONS

(All MRI breast patients must have had a Mammogram in the last 12 months. Images and reports need to be sent over if not at Raleigh Radiology)

Yes No

Reason for Visit

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Screening due to high risk (Must have a mammogram within 12 months) |
| <input type="checkbox"/> | <input type="checkbox"/> | Implant Integrity / Rupture - non-contrast exam (Must have a mammogram within 6 months; Silicone implants only) |
| <input type="checkbox"/> | <input type="checkbox"/> | Newly diagnosed Breast Cancer (Must have a mammogram within 6 months) |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a Covid vaccine? If so, date _____ and which arm <input type="checkbox"/> L <input type="checkbox"/> R |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have breast implants? Saline, Silicone or Both _____ What Year? _____ |
| | | What is the address and phone number where you had your last mammogram? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a Breast MRI before? If so, when and where? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you a high risk patient? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you tested positive for the BRCA gene? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a previous breast biopsy or breast surgery? |
| | | When and which breast? _____ |
| | | Please have the results faxed to our office. |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had chemotherapy or radiation treatment? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you currently on hemodialysis? |



Scheduling

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