

## **Patient Information Form (PIF) for Hand Symptoms**

The following patient information forms are used for patients undergoing imaging of the hand.

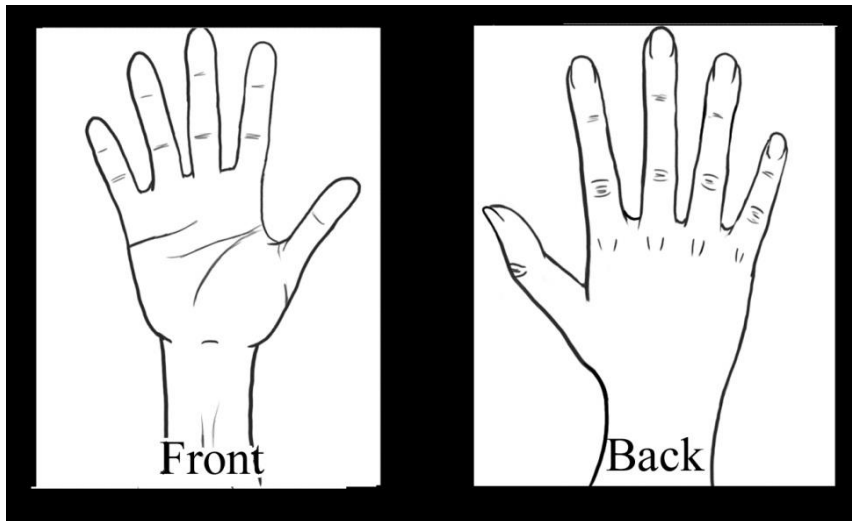
The forms, titled “Right Hand” and “Left Hand”, are used for radiographs, computed tomography (CT), and magnetic resonance imaging (MRI) examinations.



Patient Name: \_\_\_\_\_ Previous exam: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Patient pregnant: YES NO  
Medical Record #: \_\_\_\_\_ Patient breastfeeding: YES NO

### Right Hand

Please mark the location of any pain:



How long have you had your symptoms?  
  
Have you had prior surgery done on your hand? If so, please tell us the approximate date(s) and procedure(s):

If your pain is from an injury, please tell us the date of the injury describe what happened:

Please put a check if you have any of the following:	
<input type="checkbox"/>	Neck and arm pain with my hand pain.
<input type="checkbox"/>	Pain when I move my hand.
<input type="checkbox"/>	Decreased range of motion in my hand.
<input type="checkbox"/>	Pain which is worse with motion and relieved by rest.
<input type="checkbox"/>	A lump on my hand.
<input type="checkbox"/>	Abnormal sensation on the little finger side of my hand.
<input type="checkbox"/>	Abnormal sensation on the thumb side of my hand.
<input type="checkbox"/>	Decreased grip strength.

Have you ever been diagnosed with cancer? YES NO  
If yes, what type? \_\_\_\_\_

#### FOR TECHNOLOGIST USE ONLY (Fluoro time: \_\_\_\_ sec)

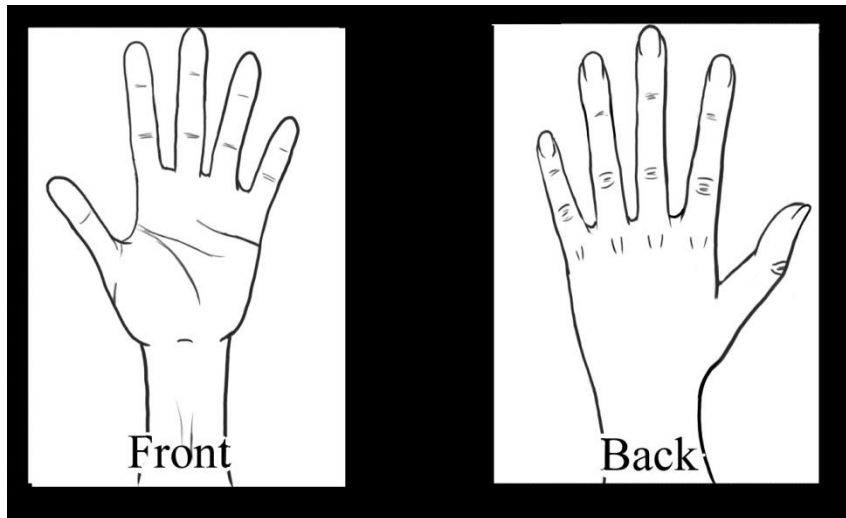
Call result?	No Yes	If "Yes", provider name/number:
Known follow-up appointment?	No Yes	If "Yes" indicate date/time and provider:
For CT and MR studies		
Was IV contrast injected?	No Yes	If "Yes": _____ mL of _____ (contrast type)
Hydration protocol?	No Yes	If "Yes", provide details:
Patient premedicated for contrast?	No Yes	If "Yes", provide details:
Abnormal response to contrast?	No Yes	If "Yes", provide details:



Patient Name: \_\_\_\_\_ Previous exam: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Patient pregnant: YES NO  
Medical Record #: \_\_\_\_\_ Patient breastfeeding: YES NO

### Left Hand

Please mark the location of any pain:



How long have you had your symptoms?
Have you had prior surgery done on your hand? If so, please tell us the approximate date(s) and procedure(s):

If your pain is from an injury, please tell us the date of the injury describe what happened:

<b>Please put a check if you have any of the following:</b>	
<input type="checkbox"/>	Neck and arm pain with my hand pain.
<input type="checkbox"/>	Pain when I move my hand.
<input type="checkbox"/>	Decreased range of motion in my hand.
<input type="checkbox"/>	Pain which is worse with motion and relieved by rest.
<input type="checkbox"/>	A lump on my hand.
<input type="checkbox"/>	Abnormal sensation on the little finger side of my hand.
<input type="checkbox"/>	Abnormal sensation on the thumb side of my hand.
<input type="checkbox"/>	Decreased grip strength.

Have you ever been diagnosed with cancer? YES NO  
If yes, what type? \_\_\_\_\_

#### FOR TECHNOLOGIST USE ONLY (Fluoro time: \_\_\_\_ sec)

Call result?	No Yes	If "Yes", provider name/number:
Known follow-up appointment?	No Yes	If "Yes" indicate date/time and provider:
For CT and MR studies		
Was IV contrast injected?	No Yes	If "Yes": _____ mL of _____ (contrast type)
Hydration protocol?	No Yes	If "Yes", provide details:
Patient premedicated for contrast?	No Yes	If "Yes", provide details:
Abnormal response to contrast?	No Yes	If "Yes", provide details: