



MYELOGRAM QUESTIONNAIRE

Patient Name: _____ **Phone:** _____

Are you taking aspirin? **Yes / No**

Are you taking blood thinner? **Yes / No** _____

Are you taking anti-depressants? **Yes / No** _____

Patient's current weight _____

Name of patient's driver _____

PREP INSTRUCTIONS:

- Drink plenty clear liquids
- No Solids 4 hours prior to exam
- No Aspirin products 3-4 days prior to exam
- No Anti-Depressants 24 hours prior to exam
- No Blood Thinner 4-5 days prior to exam
- If taking blood thinner must provide PT/PTT results to ImageSouth prior to myelogram
- Bring a list of medications to your appointment
- Must have driver

I have reviewed and confirmed the above information and attached list of contraindicated drugs, and provided a list of medication I am currently taking to the appropriate personnel.

Patient Signature

____/____/____
Date

CONTRAINDICATED DRUGS FOR MYELOGRAM / DISKOGRAM

ANTI-COAGULANTS

Must be off 4 – 5 days prior and must have PT/PTT results prior to myelogram

Coumadin – Warfarin	Lovenox
Heparin	Plavix

MAJOR TRANQUILIZERS / ANTIPSYCHOTICS

Must be off at least 24 hrs prior to exam

Adapin – doxepin	Loxitane – loxapine	Sparine – promazine
Atarax - hydroxyzine	Ludiomil - maprotiline	Stelazine – trifluoperazine
Aventyl - nortriptyline	Luvox - fluvoxamine	Surmontil – trimipramine
Buspar - buspirone	Mellaril - thioridazine	Tacaryl – methdilazine
Celexa - citalopram	Miltowne - meprobamat	Taractan - trimeprazine
Celexa - citalopram	Moban – molindone	Temaril - trimeparzine
Compazine – prochlorperazine	Navane – thiothixene	Thorazine - chlorpromazine
Cymbalta - duloxetine	Norpramine – desipramine	Tigan - promethazine
Dartal – thiopropozate	Pamelor – nortriptyline	Tindal – acetophenazine
Deprol-Meprobamate, benactyzine	Parsidol – ethopropazine	Trancopyl - chlomezanone
Desyrel - trazodone	Paxil – paroxetine	Trofranil - Imipramine
Effexor XR – venlafaxini	Petrofrane – desipramine	Vesprin – triflupromazine
Elavil – Endep-amitriptyline	Phenergan – promethazine	Vistrail - hydroxyzine
Etrafon – perphenazine & amitriptyline	Prozac – fluoxetine	Vivactil - protriptyline
Etrafon-perphenazine & amitriptyline	Quide – piperacetazine	Wellbutrin – Bupropion HCL
Haidol – haloperidol	Remeron – Mirtazapini	Wellbutrin SR – Bupropion SR
Largon – propiomazine	Repoise – butaperazine	Wellbutrin XL
Levoprome - methotrimeprazine	Serentil – mesoridazine	Zoloft – sertaline
Lexapro – ecitalopram oxalate	Seroquel – quetiapine fumarate	
Limbrirol-chlordiazepoxide & amitriptyline	Sinequan - doxepin	

MONOAMINE OXIDASE INHIBITORS – MAO'S

Must be off at least 24 hrs prior to exam

Marlpan – Isocaroxid	Nardil – Phenelzine
Matulane – Procabazine	Pamate – Tranileypromine

CNS STIMULANTS

Must be off at least 24 hrs prior to exam

Adderall	Dexedrine – Dextroamphetamine	Pondimin - Felfuramine
Aminophylline	Didrex – Benzphetamine	Preludine – Phenmetrazine
Aromatic Ammonia	Dopram – Doxapram	Riphenidate
Benzedrine – amphetamine	Luvox – Fluvoxamine	Ritalin – Methylphenidate
Chlorphentermine	Methadrine – methamphetamine	Sanores – Mazindol
Clonidine	Metrazol – Pentylentetrazone	Serzone
Concerta	Phendimetrazine	Tenuate – Diethylpropine
Coramine - Nikethamide	Phentermine	Voranil - Chortermine
Cylert – Pemoline	Picrotoxon – Phenmetrazine	



PATIENT DISCLOSURE AND INFORMED CONSENT - CT

Patient Name _____

MR # _____

Your doctor has requested that you have a Computed Tomography (CT) examination to aid in your medical diagnosis. CT is a medical imaging procedure, which utilizes x-rays and sophisticated electronic equipment to visualize the internal body structures.

PLEASE READ AND CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS:

Are you wearing a wig or hairpiece?	Yes	No	Heart disease?	Yes	No
Are you wearing dentures or partial?	Yes	No	Congestive heart failure?	Yes	No
Are you wearing a hearing aid?	Yes	No	Irregular heart beat?	Yes	No
Are you wearing an ostomy appliance?	Yes	No	High blood pressure?	Yes	No
Are you wearing an artificial eye or limb?	Yes	No	Cancer?	Yes	No
Are you wearing a neurostimulator?	Yes	No	If Yes, radiation therapy?	Yes	No
Have you ever had any surgeries?	Yes	No	If Yes, chemotherapy?	Yes	No
If Yes, when & what?			Diabetes?	Yes	No
_____			If Yes, taking Glucophage?	Yes	No
_____			Kidney disease?	Yes	No
_____			Kidney failure?	Yes	No
Is there any possibility you are pregnant?	Yes	No	Lung disease?	Yes	No
Are you nursing an infant?	Yes	No	Asthma or Emphysema?	Yes	No
Allergies?	Yes	No	Sickle cell anemia?	Yes	No
Have you ever had a reaction to contrast injection?	Yes	No	Multiple Myeloma?	Yes	No
Do you have seizures?	Yes	No	Any other medical problems?	Yes	No
Severe dehydration?	Yes	No	If Yes, describe below:		

I understand that the procedure to be performed on me involves the use of x-rays, and possibly injection needles and iodine containing solutions (x-ray dye), which may enhance the diagnostic accuracy of the procedure.

You may be receiving an intravenous contrast media and/or oral contrast media to enhance the visibility of certain tissues. Possible side effects may include, but are not limited to, pain or swelling at the site of injection, nausea, vomiting, a warm flushed feeling, potential allergic reaction including, but not limited to hives, wheezing, difficulty breathing, and in rare instances, anaphylactic shock (severe allergic reaction). More severe reactions may occur, including death, but these are very rare and the value of the diagnostic information, which may be obtained, outweighs the risk of the procedure. The purpose, benefits and complications of the contrast procedure will be explained to your satisfaction before any injection takes place. A basic kidney function test will be performed if you have a history of kidney disease, kidney failure, or have other risk factors, according to standard medical practice.

I hereby consent to any measure necessary to correct complications which may occur. I am aware that the practice of medicine is not exact science and I acknowledge that no guarantees have been made to me concerning the results of this examination.

I confirm that the information I provided is complete and accurate to the best of my knowledge.

I have read, understand, and hereby consent to this CT examination.

Patient Signature / Parent or Guardian if Patient is a Minor

Date

Witness Signature

Date



PATIENT CONTACT INFORMATION SHEET

Patient Name: _____

Social Security Number: _____

Any physician, staff, employee or representative of IMAGE SOUTH has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment and payment:

_____	_____	_____
Name	Relationship	Phone Number(s)
_____	_____	_____
Name	Relationship	Phone Number(s)
_____	_____	_____
Name	Relationship	Phone Number(s)
_____	_____	_____
Name	Relationship	Phone Number(s)

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to IMAGE SOUTH or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individuals it may be subject to redisclosure by the individual(s).

Patient Signature: _____ Date: _____

Copy given to patient (May use carbonless form to eliminate copying at front receptionist)



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is being provided to you as a requirement of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how Image South may use and disclose medical information about you to carry out treatment, payment for our health care services and for other health care operations or purposes that are permitted or required by law. It also describes your rights to access and control medical information about you. As a patient of Image South, one of the responsibilities you have entrusted to us is the protection of your personal medical information. **Our physicians and staff take this responsibility very seriously.**

The uses and disclosures listed below may be limited by Alabama Requirements described under Regulatory Requirements.

Uses and Disclosures of Protected Health Information (PHI) for Treatment, Payment and Health Care Operations

The following describes the different ways that we (Image South) may use and disclose your PHI for treatment, payment and health care operations.

For Treatment – We may use PHI about you to provide you with medical treatment or services. For example, we may disclose your PHI to doctors, nurses, or other health care professionals who are involved in taking care of you.

For Payment – We may use and disclose PHI about you so that the treatment and services you receive may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may disclose your PHI to your insurance so that they will pay for our services rendered to you.

For Health Care Operations – We may use and disclose your PHI for health care operations. Some of these operations include the use or disclosure of PHI for quality improvement, doctor/employee review activities, compliance, and the training of medical residents and other health care professionals, which includes preceptorships for health care affiliates. For example, we may compare the treatment you received to other similar episodes of care to ensure that Image South continues to provide the highest quality services.

Business Associates

We may disclose PHI to “business associates”, who perform services on behalf of our practice. Some examples of our business associates are billing and collection agencies, answering services, and courier service. Whenever an arrangement between our Practice and a business associate involves the use or disclosure of your PHI, we will have a written contract with that business associate that will protect your privacy.

Uses and Disclosures of Protected Health Information (PHI) Based on Your Written Authorization

Other uses and disclosures of PHI not covered by this notice or the laws that apply to our Practice (described below) will be made only with your written permission. If you provide us permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, thereafter we will no longer use or disclose PHI about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

Uses and Disclosures That May Be Made With Your Agreement or Opportunity to Object

Unless you object, we may disclose some of your PHI to a family member, other relative, friend, or other persons you identify. We may also notify these people about your location and condition. When you are unable to agree or object, we may still disclose your PHI for these purposes in certain circumstances.

Other Permitted and Required Uses and Disclosure That May Be Made Without Your Authorization

In addition to using and disclosing your PHI for treatment, payment and health care operations, we may use or disclose your PHI without your written authorization in the following situations:

- As required by law: We may use or disclose your PHI when required to do so by applicable law. For example, in certain circumstances, we may disclose PHI to report about an individual that we reasonably believe to be a victim of abuse, neglect, or domestic violence.
- For public health purposes.
- For health oversight activities authorized by law: We may disclose your PHI to the government for oversight activities, such as audits, investigations, inspections, licensure and disciplinary actions, and other activities necessary for monitoring the health care system.
- For Worker’s Compensation claims. (These programs provide benefits for work-related injuries or illnesses.)
- To a coroner, medical examiner or funeral director for the purpose of identifying a decedent, determining a cause of death, or as necessary to enable such parties to carry out their duties.
- For cadaveric organ, eye or tissue donations.
- For medical research purposes.
- To prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- For specialized government functions: In certain circumstances, we may use and disclose your PHI if you are a veteran or in the military. We may disclose your PHI to authorized federal officials for intelligence and other national security activities, for the protection of the President or others, and for special investigations. If you are an inmate of a correctional institution or under custody of a law enforcement officer, we may disclose your PHI to the correctional facility or official in certain circumstances.

Communication

We may use and disclose your PHI to contact you (by telephone or mail) and remind you of an appointment, or to inform you of treatment alternatives or other health-related benefits and services that may be of interest to you. We may be required to leave a message on your answering machine, when contacting you by telephone to remind you about an appointment, provide instructions prior to a diagnostic test or procedure, or to discuss payment. We may also use and disclose your PHI to encourage you to purchase or use a product or service through face-to-face communication or by giving you a promotional gift of nominal value.

Your Rights Regarding Medical Information About You

Right to Inspect and Copy You have the right to inspect and copy PHI that may be used to make decisions about your care. To inspect and copy PHI, you must submit your request in writing to our Privacy Officer. You will be notified when your record is ready to inspect or copies are completed. If you request a copy of the information, we will charge you a reasonable fee for the cost of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain circumstances.

Right to Amend If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have a right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing to our Privacy Officer, and it must explain why you are requesting an amendment to your PHI. We may deny your request in certain circumstances. If this request is denied, Image South will send you a written letter supporting reasons for denial.

Right to Request Restrictions You have the right to request a restriction or limitation on the PHI we use or disclose. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to our Privacy Officer. In your request, you must tell us: 1) What information you want to limit; 2) whether you want to limit our use, disclosure or both; and, 3) to whom you want the limits to apply. **Any previous restriction given verbally or written to an Image South employee is no longer valid and must be requested in the above manner.**

Right to request Confidential Communications You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you must make your request in writing to our Privacy Officer. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. **Any previous requests given verbally or written to an Image South employee is no longer valid and must be requested in the above manner.**

Right to a Paper Copy of This Notice Even if you agreed to receive this notice electronically, you have a right to request a paper copy by writing our Privacy Officer or by asking for a copy at the reception desk at our Image South facility.

Regulatory Requirements We are required by law to maintain the privacy of your medical information, and we must abide by the terms of this notice. (That is, the version that is currently in effect.) We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for the medical information we already have about you, as well as any information we receive in the future. We will post a copy of the current notice, with the effective date listed in the bottom right hand corner of the last page.

In addition to the privacy protections provided under federal law (which are described in this notice), Alabama law (referred to in this notice as the Alabama Requirements) requires us in certain situations to get your written consent (or, under some statutes or rules, written consent from your attorney, guardian, or upon court order) before we can use or disclose your information.

The Alabama Requirements may apply:

- If you qualify as a patient that suffers from a sexually transmitted disease;
- If you qualify as a patient that receives benefits from the State of Alabama for certain developmental disabilities or mental retardation;
- If you qualify as a patient for whom the Alabama Medicaid program has asked us to serve as a Case Management Service Provider;
- If you qualify as a patient that receives rehabilitation services through the Alabama Medicaid program;
- If you qualify as a patient that receives certain benefits under the Alabama Medicaid's Preventive Health Education program

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us. To file a complaint with Image South, contact our Privacy Officer at the address below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

If you have any questions about Image South's Notice of Privacy Practices, please contact the Privacy Officer listed below.

Privacy Officer

Connie Martin

7500 Hugh Daniel Drive – Suite 100

Hoover, AL 35242

Phone: 205-995-9388

Fax: 205-995-1255

Email address: cmartin@cypresspartners.com