

Fred S. Vernacchia, M.D.
Medical Director

Lisa M. Wieler, M.D.
Radiologist

Kenneth D. Krone, M.D.
Radiologist

Randy D. Cork, M.D.
Radiologist



High Field MRI/Open Mid-field MRI
Positron Emission Tomography (PET)/CT
16-Slice Highspeed CT scanning
4-D Ultrasonography -Color Vascular Analysis
Mammography/Stereotactic Breast Biopsy
MR & CT Angiography
Radiography/Fluoroscopy
Needle Biopsies
3D Bone Mineral Analysis
Total Body/Heart Screening
Virtual Colonoscopy

MYELOGRAM

PATIENT: _____
Last Name First Name

Telephone: _____

Appointment Date: _____

Time: _____

PRE-MYELOGRAM INSTRUCTIONS

1. No food, drink or anti-depressant medications after midnight the day of your exam.
2. Arrange for someone to drive you home after the procedure.
3. Allow 2 hours for your exam.

POST-MYELOGRAM INSTRUCTIONS

First 24-hours

1. Drink as many beverages as possible. All beverages are acceptable, except alcohol. Caffeine is good. A normal diet is also allowed.
2. Keep your head elevated slightly above the hips (recliner, pillows). Remain in bed during this time. Get up **only** to go to the bathroom. Get up slowly.
3. Take only acetaminophen (Tylenol) and/or ibuprofen (Advil) for pain or headache.

Next 24-hours

4. After 24 hours, light activity is allowed. Should you experience a headache at this time, lie flat and continue to drink plenty of fluids. The headache can last for 3-5 days.
5. If your job is strenuous, we recommend you take the day off from work.

Thereafter, normal activity may be resumed. Please call OUR office at (805) 542-9700 with any questions.

We will contact your referring physician if necessary.

Your doctor has referred you to us for the special diagnostic procedure listed above. As with all medical procedures, it carries some risks, though they are minimal. Your doctor is aware of these risks and has determined that the benefit from diagnostic information which may be obtained greatly outweighs the risk of the procedure.

CONSENT: I have discussed this procedure with the radiologist or the technologist. I understand the risks and benefits of having this procedure done. I have been given time to ask questions about this procedure and have had them answered satisfactorily. I have also been informed about any alternative procedures, if any, that may be an option for me.

I have read the above, agree with the foregoing, and give my consent to have you perform this procedure.

Signed: _____ Date: _____

Relationship to patient: Self Parent or guardian of minor patient Guardian or conservator of patient

Witness: _____