Please drink 8 ounces of water while waiting for the exam to begin.

1. **What is the reason for this test?:** *(Please check all that apply)*
   - Chronic Kidney *(Renal) Failure*
   - Acute Kidney *(Renal) Failure*
   - Prior Episode of Renal Failure  
     - When: ______________________
   - Prior Kidney transplant *(Anterior imaging)*
   - Liver failure
   - Potential kidney donor
   - Kidney Trauma / Injury
   - Kidney Stones
   - Kidney obstruction *(hydronephrosis)*
   - Diabetic
   - Hypertension  
     - Most recent Blood Pressure: ______________
   - Heart Failure
   - Other: ______________________

2. **Please describe your symptoms:** *(Please check all that apply)*
   - None
   - Pain
   - Blood in the urine

3. **Please tell us about prior kidney surgery or procedures:** *(Please check all that apply)*
   - No prior surgery or procedures to the kidneys
   - Stent
   - Kidney removed
   - Bladder removed
   - Kidney stone removed

**Height:** ______________

**Weight:** ______________

**Technologist Initials:** __________

<table>
<thead>
<tr>
<th>NAME OF PATIENT (please print)</th>
<th>SIGNATURE OF PATIENT</th>
<th>DATE</th>
<th>TIME</th>
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<tr>
<th>NAME OF TECHNOLOGIST (please print)</th>
<th>SIGNATURE OF TECHNOLOGIST</th>
<th>DATE</th>
<th>TIME</th>
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<tbody>
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</table>
1. Check for special indications:
   - Reno Vascular Hypertension *(Pre test Captopril may be required)*
   - Hydronephrosis *(Diuretic may be required)*
   - Vesico-ureteric reflux

2. Serum Creatinine Level: _________ mg / dL

3. Details of prior Procedures / Surgery:
   - Transplant
     - When: _________
     - Where: _________
     - Is transplanted kidney from a living donor? [Yes] [No]
     - Did family member donate? [Yes] [No]
   - Renal artery Angioplasty
     - When: _________
     - Where: _________
   - Urethral Stent Placement
     - When: _________
     - Where: _________
   - Prior Nephrectomy
   - Prior Cystectomy
   - Nephrostomy? *(specify side, and whether tube is open or occluded during imaging)*

4. Prior Renal Imaging Studies: *(Please check all that apply)*
   - Ultrasound
     - When: _________
     - Where: _________
   - CT
     - When: _________
     - Where: _________

5. Is the patient taking any of the following medications?
   - Ace Inhibitors *(lotensin, vasotec, accupril, monopril, capoten, altace, prinivil)*
   - Angiotensin II Receptor Blockers *(atacand, toventen, avapro, cozar, micards, benicar, diovan)*
   - Diuretic *(lasix, diazide, hydrochlorothiazide)*

6. Does the patient have a foley catheter inserted right now? *(Circle one)* [Yes] [No]

Additional Information:
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

NAME OF NUCLEAR MEDICINE TECHNOLOGIST (please print)  SIGNATURE OF NUCLEAR MEDICINE TECHNOLOGIST  DATE  TIME

NAME OF REGISTERED NURSE (please print)  SIGNATURE OF REGISTERED NURSE  DATE  TIME

(Dose Sticker Here)
Captopril Dose Administered: ______ mg  
Time of Captopril Administration: ______________________  
Captopril administered by: ______________________, RN

<table>
<thead>
<tr>
<th>Time</th>
<th>Blood Pressure Reading</th>
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<tbody>
<tr>
<td>Baseline</td>
<td></td>
</tr>
<tr>
<td>15 minutes post-Captopril</td>
<td></td>
</tr>
<tr>
<td>30 minutes post-Captopril</td>
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</tr>
<tr>
<td>45 minutes post-Captopril</td>
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</tr>
<tr>
<td>60 minutes post-Captopril</td>
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</tbody>
</table>

Captopril Renal Scans Only

[Captopril and Isotope Dose Stickers Here]