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Radiosynoviorthesis Questionnaire

Medical information before joint treatment

Last name		**First name**	
Date of birth		**Phone**	
Email			

General information

A bone scan is required before treatment. There must be no open skin lesions in the treatment area. After treatment, the joint must be rested and cooled regularly for three days.

Are you taking anticoagulant medication?	☐	Yes	☐	No

If yes: which medication and for what reason?

Have you had an operation recently?	☐	Yes	☐	No

If yes: when and what operation?

Have you ever had a thrombosis?	☐	Yes	☐	No

If yes: when and what treatment was provided?

Do you have an increased risk of thrombosis?	☐	Yes	☐	No
Are appropriate precautions being taken, such as wearing compression stockings?	☐	Yes	☐	No
Do you have a blood-clotting disorder?	☐	Yes	☐	No

If yes: since when and what measures are being taken?

Radiosynoviorthesis Questionnaire

Previous treatment and completion

Have you previously undergone radiosynoviorthesis?	☐	Yes	☐	No

If yes: when and which joint was treated?

Has your condition changed since your last radiosynoviorthesis?	☐	Yes	☐	No

How has your condition changed?

☐	improved	☐	unchanged	☐	worsened

Other comments

Date

Patient signature

Physician signature