Effective Date: July 1, 2015

CT PATIENT HISTORY

Patient Name: _____ Medical Record #: _____

Imaging Center: _____ Date of Exam: _____

Referring Dr.: _____ Reason for Exam: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

☐ Male ☐ Female: Any chance you are pregnant? ☐ Yes ☐ No Date of Last Menstrual Period: _____

MEDICAL HISTORY

List symptoms you have that are related to your problem:
Ex: pain, nausea, weight loss, etc.

_____

_____

_____

_____

List other tests you have had related to this problem:
Ex: Lab, X-Ray, Upper GI, BE, Ultrasound, MRI, CT
Test – Date – Where

_____

_____

_____

_____

Do you now or did you ever smoke? ☐ Yes ☐ No

If yes, for how many years? _____

How many cigarettes per day? _____

List any surgeries you have had and what they were for:
Date - Type of Surgery

_____

_____

_____

_____

Do you have or have you ever had cancer? ☐ Yes ☐ No

If yes: What Type – Where (body part)

_____

_____

What type of treatment did you receive?

_____

Are you finished with treatment? ☐ Yes ☐ No

Did you injure the area of interest? ☐ Yes ☐ No

If yes, describe below:

_____

SCREENING QUESTIONS

List all medications you are taking and what they are for:

_____

_____

_____

_____

_____

_____

Do you have any electronic medical device? ☐ Yes ☐ No

(Ex: Pacemaker, Defibrillator, Neuro-stimulator, Retinal implant, Drug infusion pump, Insulin pump, Cochlear implant, etc.)

If yes, list type of device below:

_____

_____

_____

_____

FOR STAFF USE ONLY

Contrast: _____ Amount: _____ cc ☐ Bolus ☐ Infusion ☐ Power Injection

Injection Site: _____ Type: ☐ Butterfly ☐ Angiocath ☐ Straight Stick

Injected By: _____ Patient Response: _____

☐ No electronic devices ☐ Electronic device present. How handled? _____

Additional Notes: _____

_____

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CT IV CONTRAST INFORMED CONSENT

Print Patient Name: _____ Date of Exam: _____

CONTRAST INFORMATION

As requested by your physician, CT contrast may be necessary to aid the radiologist in evaluating your scan. The use of this solution helps to visualize certain organs inside the body that are not normally seen well and provides the radiologist with information that is necessary in evaluating your exam.

The contrast agent is given through a small needle placed into a vein, usually on the inside of your elbow or on the back of your hand. The Food and Drug Administration has approved this agent and it is considered quite safe; however any injection carries a risk of harm including injury to a nerve, artery or vein, extravasation of the contrast under the skin, infection, potential of renal injury; or reaction to the contrast itself.

A small percentage of patients receiving CT contrast may develop a mild allergic reaction, the most common being hives. Some patients develop sneezing or itchy, watery eyes. Mild allergic reactions such as these are typically treated with an antihistamine. Uncommonly, more serious reactions have been known to occur, including life-threatening reactions. These serious reactions are rare.

SCREENING QUESTIONS

Answer the following questions so we may evaluate if you are at high risk for an adverse contrast reaction.

☐YES ☐NO FEMALE ONLY: Any chance you are Pregnant? ☐YES ☐NO Are you breastfeeding?
☐YES ☐NO Have you ever had a reaction to x-ray contrast? Type of reaction: _____
☐YES ☐NO Do you have allergies? If yes, to what? _____
☐YES ☐NO Do you have asthma?
☐YES ☐NO Have you ever had kidney disease or a kidney tumor? Describe: _____
☐YES ☐NO Have you ever had kidney/renal surgery? Describe: _____
☐YES ☐NO Have you ever had a kidney injury? Describe: _____
☐YES ☐NO Do you have a history of myeloma (Example: paraproteinemia syndromes or disease)?
☐YES ☐NO Do you have a history of collagen vascular disease? (scleroderma, systemic lupus erythematosa)
☐YES ☐NO Do you have a history of sickle cell anemia?
☐YES ☐NO Do you have Congestive Heart Failure or Heart Disease?
☐YES ☐NO Do you have a history of diabetes? If yes, insulin dependent? ☐YES ☐NO

Do you take any of the following medications? Circle any Metformin medications that apply.

☐YES ☐NO Metformin: Glucophage, Glucovance, Fortamet, Glumetza, Riomet, Metaglip, Avandamet, Acto Plus Met, Other Metformin-containing drug: _____
☐YES ☐NO Long term use of non-steroidal anti-inflammatory drugs
☐YES ☐NO Regular use of nephrotoxic antibiotics, such as aminoglycosides
☐YES ☐NO Medication for hypertension (high blood pressure)–If yes, what? _____

PATIENT ATTESTATION

If you have questions regarding your exam, please talk with the Technologist or Radiologist prior to your scan.

Your signature on this form indicates you: (1) Have read and understood the information provided on this form; (2) Have been informed about this procedure; and (3) Had a chance to ask questions.

☐ I CONSENT to having CT contrast as needed. (Check box if you agree to contrast)

☐ I DECLINE having a CT contrast injection at this time. (Check box if you disagree to contrast)

Patient Signature: _____ Date: _____

If patient is a minor or has a legal guardian, the parent or guardian must sign for consent.

Parent or Guardian: _____ Date: _____

Witness (Technologist/Radiologist): _____ Date: _____