

CT AND IV CONTRAST HISTORY AND SCREENING FORM

Patient Name _____ Date _____

Date of Birth _____ Age _____ Weight _____ Sex: Male Female

Have you had any previous X-Rays, MRIs, CTs, or Ultrasounds? Yes No

If yes: What _____ When _____ Where _____

IV Contrast History:

Do you have any personal history of:

Yes No Asthma and/or allergic respiratory disease?

Yes No Lung disease?

Yes No Diabetes?

If yes, do you take oral medication containing Metformin? Yes No

Glucophage Metaglip Avandamet Riomet Fortamet Glucovance

Yes No Kidney disease?

Yes No Heart disease, CHF, and or high blood pressure?

Yes No Stroke?

Yes No Liver disease?

Yes No Seizure disorder?

Yes No Thyroid disorder?

Yes No Cancer?

If yes: What type _____ Where _____

Radiation therapy: Yes No Chemotherapy: Yes No

Yes No Are you pregnant? Date of last menstrual period: _____

Yes No Are you currently breast feeding?

List all previous surgeries: _____

List all medications you take regularly: _____

List any drug allergies: _____

List any food allergies: _____

Have you ever had an allergic reaction to x-ray contrast (IODINE DYE)? Yes No

If yes, please explain: _____

IV CONTRAST CONSENT

Patient Name _____ Date _____

CT examinations often require the use of contrast materials to enhance the visibility of certain tissues or blood vessels. The contrast material may be given as something to drink before your exam, or injected intravenously during your exam. In rare cases, the contrast material may be need to be given in the form of an enema to help visualize the lower colon in the pelvis. The intravenous contrast material contains **IODINE** and some people may be allergic. We screen all of our patients for this prior to administering the intravenous contrast material. We use **non-ionic** contrast material which is proven to be more tolerable. Some reactions such as nausea, vomiting, skin rash, hives, or other more severe reactions can occur, but are very uncommon. With the safety of the new **non-ionic** contrast materials, adverse effects are very rare.

I have answered the questions on page 1 to the best of my knowledge and understand the information presented to me. I consent to the use of IV Contrast during my exam.

Patient, Parent or Guardian Signature _____

Date _____ Time _____

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Technologist _____

Reason for exam _____

Pertinent history _____

Oral contrast given _____ Amount _____

Rectal contrast given _____ Amount _____

IV contrast given: Contrast type _____ Amount _____ (CCs)

Needle gauge _____ IV site _____

BUN _____ CREATININT _____ Date _____

Contrast allergy: Yes No Patient premedicated for exam: Yes No

Contrast reaction: Yes No Discharge instructions given for contrast reaction: Yes No

Discharge instructions given for Metformin: Yes No

Discharge instructions given for nursing mothers: Yes No

Additional comments: _____
