

SPRING HILL
IMAGING CENTER

CT Screening

Patient Name _____

Ordering Physician _____ Date _____

Reason/Symptoms for Exam: _____

Medical History - Please Circle: Yes (Y) or No (N)

- Y N Diabetic
- Y N Taking Metformin for Diabetes
- Y N Kidney Disease / Renal Failure
- Y N Dialysis; if (Y), which days: _____
- Y N Kidney Transplant and/or Single Kidney
- Y N High Blood Pressure
- Y N Heart Disease / Heart Attack / Heart Failure
- Y N Pheochromocytoma
- Y N Sickle Cell (Acute)
- Y N Multiple Myeloma
- Y N Previous Surgeries: Please Circle Yes (Y) or No (N)
- Y N Appendix Y N Shoulder
- Y N Colon Y N Knee
- Y N Gallbladder Y N Ovary
- Y N Gastric Y N Tubal
- Y N Heart Y N Lumpectomy
- Y N Kidney Y N Mastectomy
- Y N Hip Y N Hysterectomy
- Y N Spine
- Other? Please Specify _____

- Y N Has patient had exams using IV/IVP contrast
- Y N *If yes, did you have any problems after receiving contrast
- Y N Rash Y N Difficulty Breathing/Wheezing
- Y N Itching Y N Swelling of throat, tongue
- Y N Was medical treatment required?
- Y N Medications: _____

If history of allergic reaction to IV/IVP dye:
Y N Were you medicated with Prednisone & Benadryl today?

To BE COMPLETED BY STAFF

Diabetic Renal Disease

Date of Lab _____

Bun _____ Creatinine _____ I-Stat Creatine _____

IV Access _____ Gauge _____

Site: Pre-existing New site by _____

IV Contrast

Omnipaque _____ Visipaque _____ Total given _____

Oral Contrast __ml Omnipaque 350/H2O Redicat

Complications Y N

Previous studies Y N Date _____

Technologist _____

If (3) or more categories are checked in Medical History, a history of contrast allergy, or any high risk issues regarding administration of IV contrast - fax to pharmacist @ ext 1129

Extension for Pharmacy to return call _____

Staff _____

Approved by _____ (Pharmacist)

Additional Technologist comments _____

Patient Consent
I consent to the administration of IV Contrast.
I have been informed of the risk and possible complications.

Patient Signature: _____ Date _____