The Radiology Clinic

C.T. SCAN

Patient's Name _____ ht: _____ wt:_____

Attending Physician: _____ Radiologist:_____

X-Ray #:_____ Exam Done: _____ D.O.B._____ Race: _____Sex:_____

Clinical History: _____

_____

_____

History of Cancer _____Y _____N If yes, diagnosis:_____

Treatments/Dates _____

Patient Signature: _____

QUESTIONNAIRE	YES	NO	EXPLANATION
Trauma?			
Are you pregnant?			
Previous Surgery?			Mastectomy _____ Hysterectomy _____ Cholecystectomy _____ Appendectomy _____ Bowel Surgery _____ CABG _____ Other _____
Diabetes? ☐ Hold medication sheet provided			If yes, are you taking ActoPlus Met, ActoPlus Met XR, Fortamet, Glucophage, Glucophage XR, Glumetza, Invokamet, Invokamet XR, Janumet, Janumet XR, Jentadueto, Jentadueto XR, Kazano, Kombiglyze XR, Metfomin, Riomet solution, Segluromet, Synjardy, Synjardy XR, Xigduo XR
Heart disease? Liver disease? Hypertension?			Explain:
Currently smoking?			If not smoking, how many years quit? _____
			Packs/day (20 cigarettes/pack)_____x years smoked_____ = Pack years_____
Renal (Kidney) disease?			Current CR _____ eGFR _____ Date _____ Previous CR _____ eGFR _____ Date _____ **Normal ranges: CR less than 1.5 eGFR greater than 60**
Dialysis?			What kind?_____ How often?_____ Last treatment?
Allergies?			
Previous IV contrast?			When?_____ What Kind?_____
Any previous problems with IV contrast?			
Is patient premedicated?			
Any previous related imaging exam?			
Was IV access required? IV started by : _____ IV discountinued by: _____			Needle size_____ Access: _____ Complications _____ _____
Was IV contrast given on this exam?			Amount:_____ Complications: _____
Was oral contrast given on this exam?			☐ Redicat ☐ Gastrografin

Scan Technologist: _____ History Technologist: _____ Date: _____

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Consent for Intravenous Injection of Iodine Based Contrast Material

Your physician has requested a Computerized Tomography scan (CT) to obtain diagnostic medical information. This is a non-invasive test that uses x-rays and a computer to produce images of internal body parts. The examination will involve the intravenous (IV) injection of an iodine containing contrast which allows the radiologist (X-ray doctor) to see blood vessels and internal organs, which your physician wants evaluated. As with all medical procedures, the examination carries some risks, though they are minimal. Your physician is aware of these risks and determined that the potential benefit in diagnostic information greatly outweighs the risks of the procedure.

Soon after the contrast injection you may experience a metallic taste, a warm sensation, and possibly some nausea. These sensations typically last only a short time. Other side effects may include, but are not limited to:

As with all types of intravenous (IV) injections, it is possible for the needle or catheter to slip out of the vein. If this occurs, contrast material is injected outside of the vein into the adjacent tissues (typically the hand or the arm) resulting in swelling or pain at the injection site.
Mild reaction to the contrast material including itching, sneezing, and/or upset stomach can occur.
Rarely,a more serious reaction may occur from the injection of contrast material which could result in death.
If you (a) have a history of a previous allergic reaction to contrast injection, (b) have a history of asthma or other allergic condition, (c) have diabetes or a kidney disorder, (d) have anemia, sickle cell anemia, or multiple myeloma (e) take Glucophage or (f) are pregnant, think you might be pregnant, or are breast feeding, you MUST inform the technologist.

PLEASE LIST ALLERGIES TO MEDICATIONS:

_____

_____

The benefit of this exam is to assist your physician with making a diagnosis. There may be other imaging alternatives, however, your physician believes the CT scan to be the best diagnostic test for you after evaluating your symptoms and medical condition. If you have any questions regarding this procedure, we will be glad to discuss this further with you.

Your signature on this form indicates (1) that you have read and understand the information provided in this form, (2) that the procedure has been adequately explained to you, (3) that you have had a chance to ask question, (4) that you have received all the information you desire concerning the procedure, and (5) that you authorize and consent to the performance of such procedure.

Date: _____ Signature _____

(if signed by other than the patient, indicate relationship)

Witness: _____ Account#_____