

CT SCAN CONTRAST FORM

HOW DID YOU HEAR ABOUT OUR FACILITY?

___ MD ___ FAMILY/FRIEND ___ RADIO AD ___ MAGAZINE AD

Patient Name: _____ Date: _____

_____ Weight _____ Height _____ Age _____

Reason for test/area concern: _____

Current Medications: _____

Relevant Surgeries/Dates: _____

Are you diabetic? Yes ___ No ___

Do you take Glucophage, Glucovance, Metaglip, Metformin or Avandamet? Yes ___ No ___

Previous Reaction to iodinated contrast media? Yes ___ No ___

If yes, please explain, _____

If yes, were you premedicated for today's exam? Yes ___ No ___

Known allergy to food or drugs? Yes ___ No ___

If yes, please explain _____

History of asthma? Yes ___ No ___ Sickle cell anemia? Yes ___ No ___

Kidney/Renal disease? Yes ___ No ___ Pheochromocytoma? Yes ___ No ___

Multiple myeloma? Yes ___ No ___ Possibly pregnant? Yes ___ No ___

Any personal history of cancer/tumors/lymphoma? If yes, what type _____

Previous reports on today's study would be helpful to us.

MRI Facility _____ When _____

Cat Scan Facility _____ When _____

I attest that the above information is correct to the best of my knowledge.

Patient Signature

TECHNOLOGIST AREA

Contrast Order Verified Y / N

BUN _____ Creatinine _____ Creatinine Clearance _____ REACTION? Yes ___ No ___

Amount of contrast _____ Patient received diabetic information sheet _____