CT CONTRAST CHECK LIST

PATIENT'S NAME: _____ **DATE:** _____
AGE: _____ **GENDER:**_____ **WEIGHT:**_____

PLEASE ANSWER THE FOLLOWING CAREFULLY	YES	NO	DETAILS
Are you allergic to Iodine or X-Ray dye?			
Have you had a previous IV contrast Study? IVP? CT? Etc?			
Do you have abnormal kidney function?			
Are you Diabetic? If yes please **encircle** the medications you take: ACTOS PLUS MET, AVANDAMENT, FORTAMET, GLUCOPHAGE, GLUCOPHAGE XR, GLUCOPHAGE METAGLIP, METFORMIN TABLETS, METFORMIN XR TABLETS, RIOMET ORAL SOLUTION, INSULIN, JANUMET, JANUVIA			
Do you have a history of: Drug allergies (if YES, kindly list them) Food allergies (e.g. seafood- if YES, kindly list them)			
Please list any **surgeries** you had in the past:			
Do you have any of the following? CORONARY ARTERY DISEASE (CAD) KIDNEY DISEASE (CKD, ARD) SEVERE ASTHMA OR COPD (e.g. BRONCHITIS) COLLAGEN VASCULAR DISEASE (e.g. LUPUS) PULMONARY HYPERTENSION ANGINA (CHEST PAIN) HYPERTENSION (HIGH BLOOD PRESSURE) ENDOCARDITIS CANCER (if YES, have you had SURGERY, CHEMOTHERAPHY and/or RADIATION THERAPY (Please **encircle** and when was it done)			
Are you taking NSAIDs such as: IBUPROFEN (e.g. ADVIL, MOTRIN, NUPRIN, etc) NAPROXEN (e.g. ALEVE, NAPROSYN, etc) COX-2 inhibitors (e.g. CELEBREX, etc)			If YES, how many per day?
Have you taken TYLENOL or VITAMIN C in the past 24 hours?			

I attest the above information is correct.
PATIENT'S SIGNATURE: _____ **DATE:**_____

MDX TECHNOLOGIST USE ONLY
IV CONTRAST: _____ **DOSE:**_____ **ADMIN LOCATION:**_____
ORAL CONTRAST: _____ **ML** ____**BEFORE THE EXAM**
ALLERGIC REACTION: _____**YES** _____**NO**
HYDRATION: ORAL_____ **IV**_____
If YES, describe: _____

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INTRAVENOUS ADMINISTRATION
CONTRAST MEDIA PROCEDURE INFORMED CONSENT FORM

PATIENT'S NAME: _____ DATE OF BIRTH: _____

I, hereby, authorize the Radiologist, Dr. _____ and/or whomever he/she may designate as their assistant(s), to perform the following procedure: _____
Upon myself (print name) _____. If any unforeseen conditions arise during the course of this procedure calling in his/her judgement, for procedures in addition to, or different from, those now contemplated; further request and authorize him/her to do whatever is deemed necessary.

The nature/purpose of this procedure, possible alternative methods of treatment, possible risks and complications has been fully explained to me. I acknowledge that no guarantee or assurances have been made as to the results that would be obtained from this procedure.

Further, if I am a woman, I state that I am not pregnant, lactating, or breastfeeding at this time. I have also been given the opportunity to ask questions before making this decision.

I certify that I have read carefully and fully understand this consent form, that the explanations therein refereed were made and that all blanks or statements requiring insertion of completion were filled in and the inapplicable parts if any, were stricken before me and/or witnesses, before I signed.

PATIENT'S SIGNATURE: _____ Date:_____

If minor and/or incompetent to understand/sign consent, the following party hereby gives consent.

SIGNATURE: _____ RELATIONSHIP: _____ DATE:_____

WITNESS: _____ DATE:_____