

# Advanced Imaging CT Scan Contrast Form

Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_ Age: \_\_\_\_\_

Reason for Exam/Symptoms related to today's appointment: \_\_\_\_\_

**Current Medications:** \_\_\_\_\_

**Relevant Surgeries:** \_\_\_\_\_

**Are you diabetic?** Yes \_\_\_\_\_ No \_\_\_\_\_

**Do you take Glucophage, Glucovance, Metaglip, Metformin or Avandament?** Yes \_\_\_\_\_ No \_\_\_\_\_

**Previous reaction to iodinated contrast media?** 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 \_\_\_\_\_

**Are you breastfeeding?** Yes \_\_\_\_\_ No \_\_\_\_\_ **Any food or drug allergies?** \_\_\_\_\_

**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 \_\_\_\_\_

**CT Scan** Facility \_\_\_\_\_ When \_\_\_\_\_

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

**Patient Signature:** \_\_\_\_\_

## Technologist Area

**Contrast Order Verified** Yes/ No

BUN \_\_\_\_\_ Creatinine \_\_\_\_\_ EGFR \_\_\_\_\_ Reaction? Yes \_\_\_\_\_ No \_\_\_\_\_

Amount of Contrast \_\_\_\_\_ Diabetic info sheet \_\_\_\_\_

IV Site \_\_\_\_\_ Number of Attempts \_\_\_\_\_