SAFETY SCREENING & CONSENT FORM FOR CT EXAMS

Date: ______________

Patient Information:

Name: (first, middle, last):______________________
Age: _____ DOB: ___/___/___ Male _____ Female _____
Height: __________ Weight: _______ lbs
Referring M.D.: ______________________
Why was this study requested? ______________________
____
Other problems/concerns: ______________________
____

Any prior CT exams similar to the exam you are having today? (circle)?	YES	NO

**If yes, these should be provided in advance (images and report). Otherwise please provide information on date & location of any prior exams.*______________________
____

Medical History:

Allergies: ______________________
____
List prior surgeries (type & year): ______________________
____
____
Any person history of cancer? (circle) YES or NO
____
____

For female patients:

Are you pregnant?	YES	NO
Nursing?	YES	NO
Any possibility that you could be pregnant?	YES	NO

*If you are pregnant (or think you are pregnant) or nursing, alert the technologist immediately. This exam should only be performed if considered medically essential as determined by your physician and the radiologist.

*Technologist should review form carefully and consult the radiologist regarding positive answers or other concerns. Attach M.D. order to this sheet and file.

Please complete the following section regarding intravenous (I.V.) contrast:

Have you ever received IV contrast for a CT exam?	YES	NO
*If yes, have you ever had an adverse reaction?	YES	NO

If yes, please describe the reaction, date, and treatment:
____
____

Do you have......

Diabetes?	YES	NO

*If yes, do you take any medications containing metformin?
(circle which medication you take)
Metformin, Glucophage, Glucovance, Metaglip, Riomet, Avandamet, Fortamet, Other: ______________________

Kidney problems or single kidney?	YES	NO

*If yes, please describe ______________________
*Yes answer may require laboratory determination of renal function prior to I.V. contrast administration.

Do you take medications which impair Kidney function?(e.g. chemotherapy,long-term NSAID's, no steroidal anti-inflammatories)	YES	NO
Cardiovascular disease (Heart failure,COPD)?	YES	NO
Asthma?	YES	NO
Pheochromocytoma?	YES	NO
Sickle Cell Disease?	YES	NO
Multiple Myeloma?	YES	NO
Thyroid problems?	YES	NO

*If yes, are you scheduled for a nuclear medicine thyroid study within the next 6 weeks? If so, I.V. contrast may interfere with that study.

I.V contrast is safe and uneventfully administered to millions of patients each year. Certain patients (patients with pre-existing renal dysfunction) may experience transient renal failure. Occasionally, patients may experience an adverse reaction to I.V. contrast which is typically mild (hives), but can be life-threatening (anaphylactic shock). The facility and the attending physician are prepared to treat any patient who may develop a rare adverse reaction. I.V.contrast is often required for diagnosis of certain conditions, and the risks versus benefits have been carefully considered by the ordering doctor. If you have specific questions or concerns, please inform the technologist or ask to speak with the radiologist. You have the right to refuse I.V. contrast or any medical exam.

Signature/Date: ______________________
Relationship (if other that patient): ______________________
Witness: ______________________