Height: _____ **Weight:** _____ **Age:** _____ **LMP:** _____

Contrast Risk Screening: Do you have, or have you had, any of the following conditions –

1. Yes No Kidney Disease
2. Yes No Multiple myeloma (tumor of the bone marrow)
3. Yes No Sickle Cell Disease
4. Yes No Asthma/COPD
5. Yes No Myasthenia gravis
6. Yes No Allergy/Reaction to radiographic contrast. If yes, explain:_____
7. Yes No Diabetes – **If yes –** do you take any metformin containing medication on the list given to you: Yes No

If yes you must contact your doctor after contrast injection to know when to restart.

If yes – post contrast instructions given Yes No

Patient History: Do you have, or have you had, any or the following – Include diagnosis year & any relevant comments

1. Yes No Hypertension (high blood pressure) _____
2. Yes No Thyroid Disease _____
3. Yes No Heart Attack _____
4. Yes No Stroke _____
5. Yes No Cardiac (heart) Bypass Surgery _____
6. Yes No Abdominal surgery (gallbladder, etc) _____
7. Yes No Any other surgeries _____

   _____
8. Yes No History of cancer in family _____
9. Yes No Radiation or Chemotherapy _____
10. Yes No Have you had this exam before When _____ Where _____
11. Yes No Have you had a barium study in the past 2 weeks Where _____
12. Yes No Allergies to food or medication _____
13. Yes No Do you smoke? How much _____ How many years_____ Quit?_____
14. List all medications_____

_____

_____

ALL FEMALE PATIENTS:

1. Yes No Are you pregnant? (If yes, an additional consent form will be required)
2. Yes No Have you had a hysterectomy? When _____ (year)
3. What was the first day of your last menstrual period? _____

Informed Consent: *I understand I am to have a procedure which may require the administration of intravenous and/or oral contrast media. The procedure and risks have been explained to me and my questions have been answered to my satisfaction. I authorize and consent to this procedure, including the administration of all contrast media.*

_____ _____

Patient Signature Date/Time

_____ _____

Witness signature Date/Time

HOSPITAL USE ONLY

GFR Date: _____GFR _____ (If GFR = 46 to 59 call ordering LIP, If GFR 45 or less call Radiologist and ordering LIP - both must agree).

LIP Name: _____ Date/Time called: _____ Permission: Yes No

Radiologist Name: _____ Date/Time called: _____ Permission: Yes No

Needle/catheter gauge: _____ Number of attempts: _____ Injection site_____

Type/name of IVcontrast:_____Amount_____ml Infusion rate_____ml/second Date/time_____

Type/Name of non IV contrast: _____ ____Amount_____ml Date/time_____

TIME-OUT Verified Correct: []patient []image site []side []positioning **By**: _____

[]image protocol []scanner parameters **Date:** _____ **Time:**_____

MISH

CT Scan Consent