



CT SAFETY SCREENING & PATIENT HISTORY

PLEASE PRINT: NAME: _____ AGE: _____ WEIGHT: _____

DATE OF BIRTH: _____ **PHYSICIAN(S) TO RECEIVE COPY OF RESULTS** _____

PLEASE EXPLAIN YOUR SYMPTOMS: _____

Have you ever had a previous CT? yes no **If YES**, when/where? _____

Current medications? yes no, if yes please list: _____

Any known allergies? yes no, if yes please list: _____

Any allergy to x-ray I.V. contrast or iodine? yes no **If YES**, what type of reaction? _____

PATIENT HISTORY & SCREENING INFORMATION

Have you ever had cancer? yes no **If YES**, what type? _____

Do you have asthma or have you taken medication for it within the last year? yes no

Do you have high blood pressure or have taken medication for it within the last year? yes no

Have you ever had heart problems or heart surgery? yes no **If YES**, explain _____

Do you have sickle cell disease? yes no

Do you have multiple myeloma? yes no

Have you ever had kidney stones? yes no

Does your doctor suspect kidney stones now? yes no

Do you have blood in your urine now? yes no

Do you have a history of abnormal kidney function? yes no

Have you ever had a kidney removed? yes no

Are you currently on dialysis? yes no

List any major surgeries you have had: _____

Have you ever had a previous IVP, CT, or Cardiac catheterization with I.V. contrast? yes no

Are you dehydrated, or had multiple episodes of vomiting or diarrhea in the last 72 hours? yes no

Do you have diabetes? yes no **If YES**, What medication do you take? _____

If you take glucophage (generic name: Metformin) or glucovance, what was the date and time of last dose?

Date: ____/____/____ Time: _____ a.m. p.m.

Serum creatinine level documentation is required if any of the following risk factors are present: Patient age 70 or above, insulin dependent diabetic, dehydration or suspected dehydration or any compromised renal function.

MEN: Have you ever had prostate trouble? yes no **If YES**, Please explain: _____

PLEASE SIGN BELOW, INDICATING THAT YOU UNDERSTOOD AND ANSWERED ALL THE ABOVE QUESTIONS.

SIGNED: _____

DATE: _____

WOMEN - AGES 13-50: Please see reverse

***WOMEN ONLY- AGES 13-50:**

SINCE YOUR PELVIS WILL BE EXPOSED TO X-RAYS DURING THIS EXAMINATION, WE WISH TO MAKE CERTAIN YOU ARE NOT PREGNANT.

Is there any chance you could be pregnant at this time? yes no

Has the patient had surgery to prevent them from becoming pregnant? yes no

If **YES**, list procedure _____

When was the patient's last menstrual period? ____/____/____

Is the patient on contraceptive medication? yes no

Does the patient have an intrauterine contraceptive device? yes no

Patient *signature*

Date

***FOR TECHNOLOGIST USE ONLY**

CREATININE : _____

TIME I.V. STARTED	I.V. SITE	I.V. GAUGE	# STICKS	CONTRAST AGENT	CONTRAST VOLUME	PATIENT REACTION	TIME I.V. OUT	

(REQUIRED)

Technologist signature

Ordering Physician's Statement of Responsibility for Contrast Media Administration:

Intravenous administration of iodinated contrast media has not been authorized by the interpreting physician for the indicated procedure on this patient because of the presence, or possible presence, of increased risk factors, because in his/her opinion it is not indicated, or because he/she is not available to authorize the administration at this time. By my signature below, I am verifying that I am making a clinical decision to administer the iodinated media for this procedure, that I have reviewed the patient screening information represented on this form, and that I accept full responsibility for an adverse consequences resulting from this decision.

Physician Signature

Date

Technologist/Witness Signature

Date