ALLIANCE HEALTHCARE SERVICES

Place patient label here or enter
Patient name: _____

DOB _____

CT PRE-CONTRAST SCREENING FOR IV CONTRAST ADMINISTRATION

Your physician or radiologist may deem it necessary for you to have an IV injection of a contrast agent containing iodine to improve the quality of the CT examination.

Although iodine contrast agents have been used safely in millions of patients, minor reactions (principally headache or nausea) may occur. More serious complications, including cardiac, kidney and respiratory problems as well as shock and fatalities, are extremely rare but possible.

Have you ever had an injection of contrast before? ☐ Yes ☐ No

Have you ever had a previous reaction to x-ray or CT "dye" (iodinated contrast)? ☐ Yes ☐ No
If yes, please explain: _____

Are you taking oral medication for diabetes (Glucophage, Glucovance, Actos Plus, Metformin, etc.?)
☐ Yes ☐ No If yes, date and time of last dose _____
(**Reminder for patient- DO NOT** resume taking your Metformin medication until you have contacted your healthcare provider for instructions)

Are you taking Interleukin II for chemotherapy? ☐ Yes ☐ No

Do you have a history of High Blood Pressure? ☐ Yes ☐ No

Do you have a history of Pheochromocytoma? ☐ Yes ☐ No

Do you have a history of Dialysis/Kidney Failure/Renal Insufficiency? ☐ Yes ☐ No

Do you have a history of breast cancer with lymph nodes removed? ☐ Yes ☐ No

I agree to have the CT procedure with injection of iodinated contrast material.

_____ _____ _____
Signature of Patient (Parent or Guardian if patient is a minor or incapacitated) **Date** **Time**

BUN _____ Ref. Range _____-_____ Date_____
Creatinine _____ Ref. Range _____-_____ Date_____

Contrast Name _____ Contrast Amount _____mL Lot # _____
Contrast Expiration Date _____ Injection Site _____ Flow Rate _____
IV Device Used _____ Time of Injection_____ Tech Initials _____