

CT - Part A

Factors such as weight, body shape and scan type may determine if scan can be performed.

Last Name _____
First Name _____
Date of Birth _____ Date _____

Patient: Please complete all the information contained in this boxed area.

Patient Stated Weight: _____ lbs/kgs Height: _____

Please list previous surgeries and their dates: _____

PATIENT HISTORY

Medical/Dental Procedures with Sedation in the past 24 hours? Yes No

** Pregnant Yes No

Last Menstrual Period Date _____

* Breast Feeding..... Yes No

* Personal history of Diabetes..... Yes No

* Allergies to IV dye..... Yes No

* Multiple Myeloma..... Yes No

* Sickle Cell Anemia Yes No

* Pacemaker Yes No

* Infusion Pump Yes No

* Neurostimulator Yes No

* Implanted or External Medical Devices Yes No

Asthma/COPD/Emphysema Yes No

Irregular Heartbeat..... Yes No

History of diarrhea in past 2-3 days Yes No

Any Falls within the past 30 days Yes No

If yes, most recent fall date: _____

History of Cancer..... Yes No

What Type _____

Chemotherapy _____ Radiation _____

Previous Stroke Yes No

Metallic Implant/Prosthesis..... Yes No

Orthopedic Devices Yes No

Surgical Clips..... Yes No

Epilepsy (Seizures)..... Yes No

Catheter or Drainage Tube..... Yes No

Claustrophobia Yes No

Difficulty Swallowing..... Yes No

Dental Braces..... Yes No

Removable Dental Work..... Yes No

Did you self-medicate
for today's procedure? Yes No
If yes, do you have a driver? Yes No

Any previous imaging study related to the reason for today's exam? Yes No

Type of Exam _____ Facility _____ Date _____

I understand the risk of having an x-ray while pregnant and I do not believe I am pregnant.

Initial: _____ Date: _____

Signature of Patient: _____ Date: _____ Time: _____

(Parent or Guardian if patient is a Minor or Incapacitated)

Relationship: _____

(**) Pregnancy requires signed informed consent. Single asterisk (*) items may require further discussion between Technologist and Radiologist. Document any verbal approvals or instructions on Part B.

Tech Comments: _____

I have reviewed each response with the patient or their legal guardian, power of attorney, next of kin, etc. and **PERFORMED CLINICAL PAUSE #1.**

Technologist Signature: _____ Date: _____

CT - Part B

Medical Record # / Accession #: _____

Exam Ordered - CT of: _____

Facility Name: _____

Referring Physician: _____

Diagnosis: _____

Reason for Exam/Clinical Symptoms: _____

Last Name _____
First Name _____
Date of Birth _____ Date _____

II Clinical Pause #1: Correct Imaging Protocol
Correct Patient Correct Procedure
Correct Body Part Correct Positioning
Reviewed Physician Order Tech Initials _____

Patient's preferred language for discussing healthcare: English Spanish Other

Is the patient allergic to any medications, food, or latex?

Yes No If Yes, please list: _____

List all current medication(s) and check the ones taken today:
(Include birth control and over the counter, ointments, herbals, vitamins, medication patches, etc.)

_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
_____ <input type="checkbox"/>	_____ <input type="checkbox"/>
_____ <input type="checkbox"/>	_____ <input type="checkbox"/>

Oral Contrast Name _____
Amount _____ mL
Lot # _____
Exp. Date _____
Administered By: _____
Title: _____

Patient unaware of current medications Patient not on any medications
 Medication list attached (Includes name & DOB)

Barriers to Learning <input type="checkbox"/> Yes <input type="checkbox"/> No
Type: <input type="checkbox"/> Language <input type="checkbox"/> Hearing <input type="checkbox"/> Other _____
Intervention: <input type="checkbox"/> Interpreter ID# _____ <input type="checkbox"/> Repeat Questions <input type="checkbox"/> Family/Significant Other _____

Will the Patient receive an IV injection? Yes No If yes, A054(a) must be completed and signed.

Injection site evaluated? Yes No N/A Note appearance _____

Post Injection Instructions given (applicable to all patients who receive an injection). Yes No N/A

RECEIPT OF VERBAL ORDERS, TEST RESULTS, MODIFICATIONS, OR OTHER INSTRUCTIONS Yes No

Information Received: _____

Readback confirmed with _____ Title _____ Date _____ Time _____

Technologist Signature: _____ Date _____ Time _____

Radiologist Signature: _____ Date _____ Time _____

Patient was encouraged to "Speak up" with questions or concerns. Yes No

Technologist Comments _____

CTDI _____ mGy DLP _____ mGy-cm Anatomy _____

CTDI _____ mGy DLP _____ mGy-cm Anatomy _____

Dose at or below threshold? Yes No If no, why? _____

If over threshold, was CT Log completed? Yes No

II Clinical pause #2 prior to image transfer (Correct labeling, annotation and image quality)? Tech Initials _____

Prior to release, patient was assessed and found impaired? Yes No If yes, supervising physician notified? Yes No

If patient refuses further assessment, notify supervising physician and Team personnel to follow policy #5023.

Team Member Signature and Title: _____

PATIENT SIGNATURE BELOW ONLY AT THE COMPLETION OF EXAM.

I retrieved all of my personal belongings upon completion of exam. Yes No N/A

I give my consent to receive electronic communications & survey invitations. Yes No N/A

(Data rates may apply depending on your mobile carrier.)

My preferred method to receive communications and survey is: Text Msg E-mail Tablet

Cell #: (____) _____ E-mail: _____

I have received a copy of the terms and conditions for electronic communication.

Yes No N/A

Patient Signature _____