CT Part A - RETAIL

Last Name: _____

First Name: _____

DOB: _____ Date: _____

Height _____ Weight _____ lbs/kgs

Please answer the following screening questions carefully:

Please list previous surgeries and their dates:

_____

_____

Any medical or dental procedures with sedation in the past 24 hours? ☐ Yes ☐ No

Pregnant or Breast Feeding ☐ Yes ☐ No LMP _____ *(Pregnancy requires informed consent)*

Medication injection device (OnPro)	☐ Yes	☐ No	History of Cancer	☐ Yes	☐ No
Personal History of Diabetes	☐ Yes	☐ No	What type _____		
Allergies to IV dye	☐ Yes	☐ No	Chemo _____ Radiation _____	☐ Yes	☐ No
Multiple Myeloma	☐ Yes	☐ No	Previous stroke	☐ Yes	☐ No
Sickle Cell Anemia	☐ Yes	☐ No	Metallic Implants / Surgical Clips	☐ Yes	☐ No
Pacemaker or Neurostimulator	☐ Yes	☐ No	Orthopedic Devices / Prosthesis	☐ Yes	☐ No
Implanted or External Medical Devices	☐ Yes	☐ No	Epilepsy (Seizures)	☐ Yes	☐ No
Asthma/ COPD/Emphysema	☐ Yes	☐ No	Catheter or drainage tube	☐ Yes	☐ No
Irregular Heartbeat	☐ Yes	☐ No	Claustrophobia	☐ Yes	☐ No
History of Diarrhea in past 2-3 days	☐ Yes	☐ No	Difficulty Swallowing	☐ Yes	☐ No
Self-medicate for today's exam?	☐ Yes	☐ No	Braces/Removable Dental Work	☐ Yes	☐ No
If yes, do you have a driver?	☐ Yes	☐ No	Any recent falls? When _____	☐ Yes	☐ No

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

Type of Exam _____ Facility _____ Date _____

GENERAL CONSENT/ACKNOWLEDGEMENT

I consent to the ordered exam. I understand that I have the right to refuse or stop the exam at any time and I have the right to ask questions and discuss my concerns.

I have read the screening information and answered the above questions accurately.

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

I authorize Alliance Healthcare Services, Inc., its subsidiaries and affiliates to bill on my behalf Medicare, or any other insurance company providing benefits to me, for services performed by Alliance and I authorize payment to be made directly to Alliance. In Medicare assigned cases, Alliance agrees to accept the Medicare "allowable charge" as the full charge.

I understand that I am responsible for the payment of any patient liability including, but not limited to, deductibles, coinsurance or non-covered charges. Self-pay/Cash pay patients are expected to pay for services at the time services are rendered unless prior payment arrangements have been made.

I have been offered a printed copy of Alliance's Notice of Privacy Practices and I acknowledge receipt of the Patient Rights and Responsibilities.

I have read and I understand, acknowledge and agree to the content of this General Consent form and have had my questions answered. I give my consent to receive electronic communications and survey invitations if applicable.

Patient Signature: _____ Date: _____ Time: _____

(Parent or Guardian if patient is a Minor or Incapacitated) Relationship: _____

CT - Part B

Last Name _____

First Name _____

DOB _____ Date _____

Medical Record # / Accession #: _____

Referring Physician: _____

Ordered Exam – CT of: _____

Facility Name: _____

Reason for Exam/Clinical Symptoms: _____

Clinical Pause #1: ☐ Correct Patient ☐ Correct Procedure ☐ Correct Protocol ☐ Lowest Dose
☐ Correct Body Part ☐ Reviewed Referring Physician Order Tech Initials _____

Falls risk assessment was conducted by Alliance Team Member upon first greeting the patient. TM Initials _____

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

Patient's preferred survey method: ☐ Text ☐ E-mail ☐ Tablet ☐ N/A- No survey

Cell number or e-mail address: _____

Barriers to Learning: ☐ Yes ☐ No	
Type	**Intervention**
☐ Language	☐ Interpreter ID# _____
☐ Hearing	☐ Repeat/Write Questions
☐ Other	☐ Family/Significant Other

Allergies to any medications, food or latex? ☐ Yes ☐ No

If yes, please list: _____

List all current medications including all prescriptions, over the counter items, ointments, vitamins, herbals and medication patches. Attach list if available. Check the box for any medications taken today.

_____ ☐ _____ ☐ _____ ☐

_____ ☐ _____ ☐ _____ ☐

_____ ☐ _____ ☐ _____ ☐

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

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

Clinical Pause #2 conducted prior to image transfer? ☐ Yes ☐ No Tech Initials _____
(Correct labeling, annotation and image quality)?

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

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 member to follow policy #5023.

Tech Comments:

_____

_____

All belongings have been returned to the patient following the exam. ☐ Yes ☐ No ☐ Inpatient-N/A

Technologist Signature: _____

ALLIANCE HEALTHCARE | RADIOLOGY

Last Name _____

First Name _____

Date of Birth _____

COMPUTED TOMOGRAPHY CONTRAST ADMINISTRATION RECORD

Technologist Use Only

Previous injection of contrast? ☐ Yes ☐ No

Previous reaction to x-ray or CT "dye" (iodinated contrast)? ☐ Yes ☐ No

If yes, please explain: _____

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 Metformin based medication until patient has contacted their healthcare provider for instructions)

Taking Interleukin II for chemotherapy? ☐ Yes ☐ No

History of High Blood Pressure? ☐ Yes ☐ No

History of Pheochromocytoma? ☐ Yes ☐ No

History of Dialysis/Kidney Failure/Renal Insufficiency? ☐ Yes ☐ No

History of breast cancer with lymph nodes removed? ☐ Yes ☐ No

History of arterio-venous (AV) fistula? ☐ Yes ☐ No

BUN _____ Reference Range _____-_____ Date_____

Creatinine _____ Reference Range _____-_____ Date_____

IV Contrast Name _____

IV Contrast Amount _____mL

Lot # _____

IV Contrast NDC # _____

IV Contrast Expiration Date _____

Injection Site _____

IV Device Used _____

Oral Contrast Name:_____

Amount:_____Exp. Date: _____

Lot # _____

Administered By: _____

Title: _____

Multi-dose vial ☐ Single-dose vial ☐ If single dose vial, amount of discarded contrast _____mL

Time of Injection_____ Flow Rate _____mL/s Injecting Tech Initials _____

Injection site evaluated prior to patient's release? ☐ Yes ☐ No

Note appearance:_____

Post Injection Instructions given ☐ Yes ☐ No

_____ _____ _____

Signature of Technologist **Date** **Time**