

# 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Pregnant or Breast Feeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No	LMP _____	(Pregnancy requires informed consent)
Medication injection device (OnPro)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	History of Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Personal History of Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	What type _____	
Allergies to IV dye	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chemo _____ Radiation _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Multiple Myeloma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Previous stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sickle Cell Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Metallic Implants / Surgical Clips	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pacemaker or Neurostimulator	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Orthopedic Devices / Prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Implanted or External Medical Devices	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Epilepsy (Seizures)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma/ COPD/Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Catheter or drainage tube	<input type="checkbox"/> Yes <input type="checkbox"/> No
Irregular Heartbeat	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Claustrophobia	<input type="checkbox"/> Yes <input type="checkbox"/> No
History of Diarrhea in past 2-3 days	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty Swallowing	<input type="checkbox"/> Yes <input type="checkbox"/> No
Self-medicate for today's exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Braces/Removable Dental Work	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, do you have a driver?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Any recent falls? When _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any previous imaging study related to the reason for today's exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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

Medical Record # / Accession #: \_\_\_\_\_


Referring Physician: \_\_\_\_\_

Ordered Exam – CT of: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Reason for Exam/Clinical Symptoms: \_\_\_\_\_

Last Name	_____
First Name	_____
DOB	_____
Date	_____

 **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: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Type	Intervention
<input type="checkbox"/> Language	<input type="checkbox"/> Interpreter ID# _____
<input type="checkbox"/> Hearing	<input type="checkbox"/> Repeat/Write Questions
<input type="checkbox"/> Other	<input type="checkbox"/> 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.

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

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: \_\_\_\_\_