CT - Part B

Medical Record # / Accession #: ______________________________

Referring Physician: ______________________________

Ordered Exam – CT of: ______________________________

Facility Name: ______________________________

Reason for Exam/Clinical Symptoms: ______________________________

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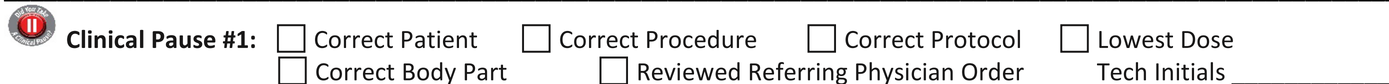
Last Name ______________________________
First Name ______________________________
DOB ______________ Date ______________



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 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, and herbals. Attach list if available.
Check the box for any medications taken today. Oxygen: Flow Rate__________Liters/Minute Cylinder Pressure__________PSI

____________________ ☐	____________________ ☐	____________________ ☐
____________________ ☐	____________________ ☐	____________________ ☐
____________________ ☐	____________________ ☐	____________________ ☐

☐ 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:

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

Technologist Signature: ______________________________