CT Patient Questionnaire

Social Security #

_____-_____-_____

Date: / /	Age:	Date of Birth: / /

You are scheduled for an exam that may require intravenous injection of a substance containing iodine. Occasionally there are side effects to this procedure. Please check off any of the items which pertain to you and sign at the bottom. Thank you for completing this questionnaire.

1. Have you ever had surgery or any similar invasive procedure? No ☐ Yes☐
If yes, please list:

Type:	Date:
Type:	Date:
Type:	Date:

2. Have you had any previous diagnostic imaging tests? Please list below. No ☐ Yes☐

Procedure	Date	Body Part	Facility Name & Address	Phone No.
MRI				
CAT SCAN				
X-RAY				
ULTRASOUND				
NUCLEAR MEDICINE				

3. Are you currently taking or have you recently taken any medication? No ☐ Yes☐
If yes, please list

4. Do you have anemia or any diseases that affect your blood, a history of renal disease or seizures? No ☐ Yes☐
If yes, please list

5. Do you have drug allergies or other history of allergies? No ☐ Yes☐
If yes, please list

6. Have you ever had asthma, allergic reaction, respiratory diseases, or other reaction to iodine or any other contrast material or dye used for a MRI or CT examination? No ☐ Yes☐
If yes, please list

7. Do you have, or have you ever had any of the following symptoms/diseases?

Heart Problems No ☐ Yes☐

Blood disorders No ☐ Yes☐

Kidney problems No ☐ Yes☐

Seizures No ☐ Yes☐

Diabetes No ☐ Yes☐

Asthma No ☐ Yes☐

8. Are you taking any kind of medication to control diabetes? No ☐ Yes☐

9. Are you taking Glucophage (XR), Glucovance Avandamel Fortamet or Metaglip? No ☐ Yes☐
If yes, please contact your doctor within 48 hours after exam to obtain a Creatinine lab test.

10. If you are of age 60 or over please provide your date of birth: / /

FOR FEMALE PATIENTS

11. Are you pregnant? No ☐ Yes☐

I understand that this procedure/test may have a negative impact upon an unborn fetus. Therefore, if I am pregnant, or suspect that I may be pregnant, I understand that I should consult with my family doctor or OB/GYN before having this test.

Patients Initials:_____

12. Are you presently a nursing mother? No ☐ Yes☐

SIGNATURE

I acknowledge that because the above information will be reviewed by a physician in connection with the performance of this diagnostic test, the information that I provide above must be accurate. Therefore, I certify that the above information is true and correct.

Patients Signature: _____ Date:_____

Physicians Signature: _____ Date:_____

Important Notice To:

- Patients over 60 years of age
- Patients with suspected kidney impairment
- Patients with diabetes

The iodine contrast material may, under certain conditions, cause loss of kidney function or complete kidney failure. In order for your physician to fully access whether you may receive this contrast material, he or she should have the opportunity to determine your kidney function. Accordingly, you understand that you may not undergo a CT Scan with IV iodine contrast unless your blood creatine and BUN levels are appropriate for this procedure and this may be postponed until such time as such levels can be determined.

Patients Initials: _____

SPECIAL NOTICE TO DIABETIC PATIENTS

If you take Metformin or a medication containing Metformin, including but not limited to Glucophage, Glucophage XR, Glucovance, Avandamet, Fortamet, Riomet or Metaglip, you acknowledge that you have been instructed not to take any further doses of such medication for two days (48 hours) after your CT Scan procedure, unless otherwise directed by your personal physician. Your physician may prescribe alternative medications for you during this period. You should contact you doctor to determine if alternative medications are needed today after your procedure. The iodinated contrast material to be injected in your body in connected with the CT Scan procedure may under certain conditions, may prevent the normal excretion of Metformin from your body and result in lactic acidosis, a condition that could result in your death.
Additionally, you understand that you are to contact your physician immediately so that he or she can arrange for the performance of a blood test to determine your renal function within 48 hours of this CT Scan procedure.

Patients Initials _____

Informed Consent for CT Scan with IV Contrast

I understand that my doctor has referred me for a CT Scan procedure which involves injecting iodine containing contrast material into my body. This procedure is performed under a physician's supervision. The information obtained may help my physician in the management and treatment of my medical condition.

Risk and adverse reactions

Examinations requiring injections of iodine contrast material are commonly performed and generally safe. However, as with any procedure minor reactions may occur such as nausea, vomiting. Hives and itching. These are temporary symptoms which often do not require treatment. Moderately severe reactions, including swelling of the face and throat, wheezing, narrowing of air passages, kidney failure, extravasations in the soft tissue, unstable blood pressure, occur rarely. Serious reactions are very rare. These may include anaphylactic shock, heartbeat irregularities, seizures, unconsciousness and cardiac arrest. It is extremely unlikely, but still possible that this procedure may result in death.

I consent to the CT Scan with iodine contrast to determine my medical condition. I certify that I have received adequate information concerning the nature of the above indicated examination and that any questions that I asked were answered to my satisfaction. I also consent, in the event of the onset of a medical condition requiring emergency treatment, to the treatment of such condition by clinical staff, including medical examination and the care and treatment of the emergency condition and calling emergency rescue service (911) I also certify that all information which I have given in connection with this procedure is true and correct.

I Acknowledge this facility is strictly a testing facility that is responsible for performing diagnostic tests ordered by my physician. I also acknowledge that this facility is not responsible for any decision regarding the ordering of the test or any decisions regarding my subsequent care which may be based upon the outcome of the diagnostic test. This facility may be required under rules and regulations governing the payment for the diagnostic test to require me and my physician to provide this facility with certain information documenting the medical necessity and appropriateness of the test. I acknowledge that such information is to be provided for that purpose; however this facility is not responsible for determining medical necessity of such test.

SIGNATURES
Patients Signature _____ Date _____
Physicians Signature_____ Date _____

SUPERVISING PHYSICIAN ASSESSMENT		
Does the questionnaire show any contradictions, or reasons why this patient should not have the contrast injection?	No ☐	Yes☐
Has the patient been visually examined for any signs of distress, general debilitation, leg swelling, dyspnea or CHF?	No ☐	Yes☐
Does the clinical history conflict with the exam for the contrast injection?	No ☐	Yes☐
Signature of Supervising Physician _____ Date _____		