

CT SCAN – SCREENING QUESTIONNAIRE FOR INJECTION OF INTRAVASCULAR RADIOGRAPHIC IODINATED CONTRAST

MRN:
Patient Name:
(Patient Label)

Height _____ ft _____ inches Weight _____ lbs

1. CT Non Contrast - **All Patients**	Yes	No	Unknown
Is this safety screening form being waived by MD due to urgency? If yes, enter MD's name and pager ID: _____			
Physician Name _____ Pager ID# _____			
Do you weigh more than 440 lbs.?			
Is there a possibility you may be pregnant? If Yes, physician consultation is required.			
Pregnancy gestational week? _____			
2. CT with Contrast and/or Interventional CT **All Patients Receiving IV Contrast**			
Are you allergic to iodine, or had complication with injected contrast, or have severe multiple allergies? If yes, describe complication:			
If yes, did you receive medication specific to iodine allergy 24 hours prior to exam?			
Are you on dialysis? If yes, when is your next dialysis appointment?			
Do you have a Central Venous Line / PICC Line / Port?			
Have you ever been diagnosed with asthma or use an inhaler? If yes, please bring your inhaler to the CT scan appointment.			
Have you ever been diagnosed with diabetes? If yes please list the medications:			
Are you taking METFORMIN containing medications? If yes, list medications: _____ (Referring MD to withhold METFORMIN drugs 48 hours from scan)			
Have you had kidney surgery or any kidney disease, or any family history of kidney failure?			
Have you had or are you being evaluated for solid organ transplant? (Liver, Kidney, heart)			
Have you ever been diagnosed with high blood pressure or heart failure?			
Have you ever been diagnosed with Myeloma, Lupus, Scleroderma, Gout, Sickle-cell disease, Hyperthyroidism, or Myasthenia Gravis?			
Do you take daily pain or anti-inflammatory drugs? (except Baby Aspirin)			
Have you had chemotherapy within the past month?			

**CT SCAN – SCREENING QUESTIONNAIRE
FOR INJECTION OF INTRAVASCULAR
RADIOGRAPHIC IODINATED CONTRAST**

MRN: _____
Patient Name: _____

(Patient Label)

3. Cardiac/Coronary CT **All Patients Scheduled for Cardiac CT**	Yes	No	Unknown
Have you ever used beta blockers? If yes, please comment on adverse reactions:			
Are you taking any medications typically used to increase blood flow, for erectile dysfunction syndrome or for pulmonary hypertension such as Cialis, Viagra, Tadalafil, Adcirca? If so, please withhold this medication for 48 hours.			

This form was completed by (Print Name): _____

Patient or Representative Signature _____ Date _____ Time _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Interpreter Signature _____ ID # _____ Date _____ Time _____