CT SCREENING FORM

Patient Name (please print): _____ **Date:** _____

Your doctor has scheduled you for an x-ray examination that requires an injection of contrast media into your bloodstream. The contrast media (also called x-ray dye or iodine) shows up white on x-ray film or CT images and helps the Radiologist interpret the films.

The IV contrast is given through a needle placed into a vein. Normally, contrast media is considered quite safe; however, any injection carries a small risk, including injury to a nerve, artery or vein, infection or an allergic reaction to the contrast media being injected. Rarely contrast may leak from the vein being injected. If a large amount leaks it has the potential to cause tissue injury. Occasionally, a patient will have an allergy to the IV contrast media such as hives. Uncommonly, a serious reaction can occur. The physicians and staff of the CT Department are trained to treat these reactions. Such a severe reaction is rare, occurring in approximately 1 out of 10,000 exams.

Please review and answer the following questions:

Do you have allergies to Iodine or IV contrast media? ☐ Yes ☐ No

If yes, what type of reaction? _____

Have you had IV contrast media before? ☐ Yes ☐ No

Have you ever been diagnosed with cancer? ☐ Yes ☐ No

If yes, what type? _____

Have you had chemotherapy, date of last dose ☐ Yes ☐ No

Do you have multiple myeloma, sickle cell disease, pheochromocytoma? ☐ Yes ☐ No

Do you have kidney disease? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No

Do You have a Port or PICC line? ☐ Yes ☐ No

Do you have CHF congestive heart failure? ☐ Yes ☐ No

Are you receiving antibiotic therapy? ☐ Yes ☐ No

Do you have a neurostimulator, or a deep brain stimulator? ☐ Yes ☐ No

Please list all surgeries of the area being scanned:

_____

Have you had previous CT exams? ☐ Yes ☐ No

If yes, what facility? _____

Weight _____

Female Patients Only:

Is there any chance you could be pregnant? ☐ Yes ☐ No

Date of last menstrual period? _____

Are you currently breastfeeding? ☐ Yes ☐ No

Patient Signature: _____ Date: _____ Time: _____

TECHNOLOGIST USE ONLY

Oral Contrast _____ **Time Given** _____

eGFR: _____ **Date:** _____ **IV Line:** _____ **Gauge/Site** _____

Patient's Nurse: _____ **Protocol #:** _____ **Protocol Rad:** _____

Technologist's name: _____

PATIENT LABEL

SWEDISH

SEATTLE, WASHINGTON

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