CT Questionnaire

To assist the radiologist in interpreting your study and help the technologist perform the correct exam for you, please answer the following medical questions:

1. Current Height _______     Weight _______
2. Is there any possibility that you are pregnant?   Yes   No
3. Have you ever had IV contrast (contrast media or X-ray dye) before?   Yes   No
4. Are you allergic to IV contrast (contrast media or X-ray dye)?   Yes   No
   Please list any allergies to medications or drugs:

5. Do you have a history of the following conditions?
   - High Blood Pressure ................................................................. Yes   No
   - Diabetes ................................................................................. Yes   No
   - Heart Disease ....................................................................... Yes   No
   - Kidney Disease .................................................................... Yes   No
   - Asthma/Other Lung Disease .................................................. Yes   No
   - Are you/Have you ever been a Smoker ................................. Yes   No
   - Blood Clotting Disorder ....................................................... Yes   No
   - Hepatitis B or C .................................................................... Yes   No

6. Do you take Glucophage, Metformin, Glucovance, or Avandamet?   Yes   No

7. Last time you ate or drank anything other than the CT Prep: ____________________________

8. Have you had any of the following tests that pertain to the area we are imaging today?
   At which facility / Approximate date
   - Bone Scan   Yes   No
   - CT Scan     Yes   No
   - MRI Scan    Yes   No
   - X-rays      Yes   No
   - Ultrasound  Yes   No

9. Please list any surgery you have had in or near the area we are imaging today.

10. Have you ever been diagnosed with cancer?   Yes   No
    If yes, in what part of your body? When were you diagnosed?

11. Have you had radiation therapy for cancer?   Yes   No
    If yes, when was it completed?

12. Have you had chemotherapy?   Yes   No
    If yes, when was it completed?

PLEASE TURN OVER
Valley Diagnostic Imaging Services – Olympic Building

IV Contrast Agent Consent

You have been scheduled for a CT exam that may require an injection of a contrast material (X-ray dye) into your bloodstream. This material is injected through a small needle placed in a vein. It provides added diagnostic information that helps the radiologist interpret the CT images.

The contrast substance is considered quite safe. However, an injection carries a slight risk, including injury to a vein, infection, or reaction to material being injected. Physicians and technologists at Valley Diagnostic Imaging Services are trained to treat reactions to contrast material. Most reactions are quite mild, consisting of sneezing or hives. Serious reactions are uncommon (approximately 1 in 1,000). Very rarely (less than 1 in 100,000) death related to contrast administration has occurred.

Certain patients are at greater risk for experiencing a reaction to the contrast material.

Patients who are at higher risk for adverse effects are people who:

- have already had a moderate or severe allergic-type reaction to contrast material which required treatment
- have severe allergies, asthma, or hayfever
- have severe or incapacitating heart disease
- have diabetes or severe kidney disease
- have multiple myeloma

***Warning: Use of Glucophage, Glucovance, Metformin, or Avandamet oral medications for diabetes, must be discontinued at the time of procedure. These drugs should not be taken again for at least 48 hours following your procedure and until your doctor ensures that your kidney function is normal.

If you have any questions, please ask the technologist performing your exam.

I hereby consent to the above described procedure to be performed by VDIS - Olympic Building. I have read the above information and my questions have been answered.

Patient Signature: ________________________________________ Date: _______________ Time: _______________
(or authorized representative)

Relationship to patient: ____________________

Witness Signature: ________________________________ Date: _______________ Time: _______________

FOR OFFICE USE ONLY

1. Contrast Type and Amount: ___________________________ Max Rate: ______________ ml/sec _______
2. Technologist: ______________________________ Radiologist: ______________________________
3. Access Device Type: Intima/Insyte Needle Gauge: 22/20/18 Insertion Site: ___________________________
4. Started By: ____________ Hub Scrubbed per protocol by: ____________ DC’d By: ______________
5. Complications: _________________________________