CT - COMPUTERIZED AXIAL TOMOGRAPHY

☐ CMI -BEND ☐ CMI, SCHC BEND

☐ CMI - SCHC REDMOND ☐ CMI - SCHC MADRAS

☐ CMI - SCHC PRINEVILLE

Today's Date: ____/____/_____ Name:_____ Weight & Height _____

Date of Birth: ____/____/_____ Age: _____ ☐Male ☐Female Referring Dr: _____

Briefly describe the problem(s) you are experiencing that made you see your doctor: _____

_____

_____

Have you ever had any surgery in the area you are currently having problems? ☐ Yes ☐ No

Type of Surgery: _____

Do you have a personal history of cancer in any part of your body? ☐ Yes ☐ No

What **part** of your body and **when** was the diagnosis made? _____

_____

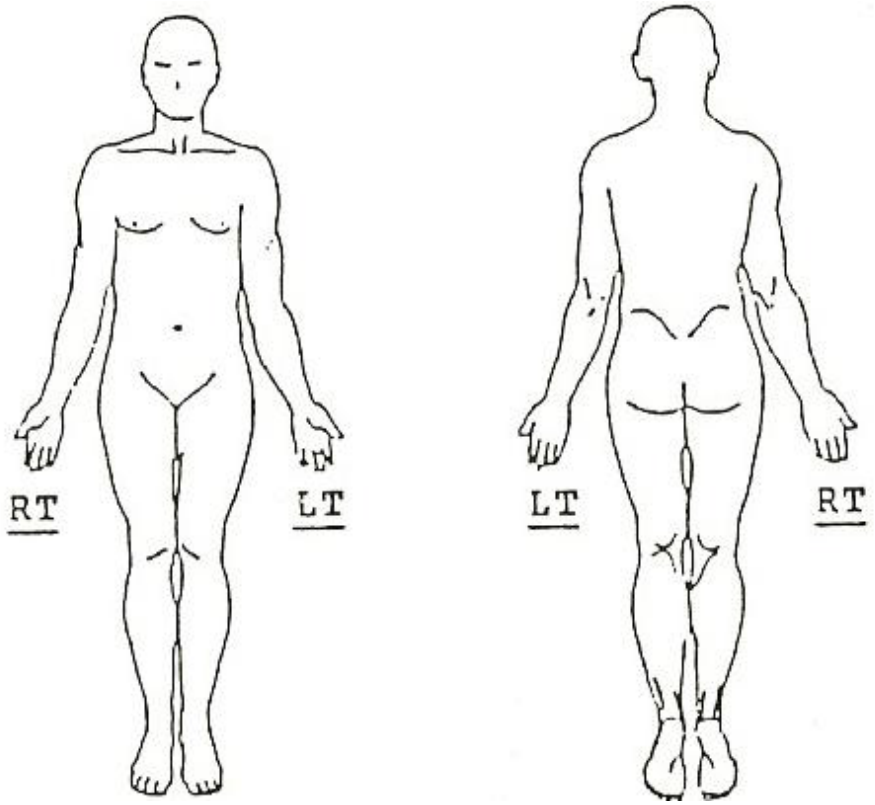
PLEASE INDICATE BELOW ANY PREVIOUS PERTINENT STUDIES YOU HAVE HAD, WHEN THEY WERE PERFORMED AND AT WHAT FACILITY:

X-Rays: _____ MRI: _____

CT Scan: _____ Nuclear Medicine: _____

Ultrasound: _____ Other: _____

Please use this diagram to mark where you think your problem is located or where you are feeling pain →



CONSENT FOR CONTRAST MATERIAL INJECTION

CT uses a thin beam of low dose diagnostic x-ray with advanced computer technology to create a series of images that the radiologist reviews. Your physician has chosen contrast CT because it provides an ability to see certain kinds of pathology.

The contrast material is a clear liquid given through a small needle and injected into a vein in your arm. Normally, contrast material is considered quite safe. However, any injection carries a slight risk of harm including injury to a nerve, artery, vein and infection or allergic reaction. Occasionally the patient will develop sneezing or hives. Uncommonly, (one case in a 1000) a serious reaction to contrast occurs. Vary rarely, (one case in 40,000) death has occurred related to the contrast administration. The risk of such a severe consequence is similar to that from the administration of penicillin. Our radiologist and staff are trained to treat these reactions.

Certain patients are at higher risk for experiencing a reaction to the contrast agent. We would like to identify these patients in order to take appropriate measures to try to prevent a reaction.

PLEASE FILL OUT THE CHECK LIST BELOW TO HELP US PREPARE FOR YOUR CT SCAN:

YES	NO	
☐	☐	Are you on dialysis or do you have a history of renal failure?
☐	☐	Have you had a kidney removed (nephrectomy)?
☐	☐	Are you on any Metformin containing medication? (Treatment for Diabetes, Polycystic Ovary Syndrome, and Antipsychotic Therapy induced weight gain)
☐	☐	Do you have a history of cancer with chemotherapy or any chronic illness? (multiple myeloma, thyroid, adrenal)
☐	☐	Do you have a history of heart disease?
☐	☐	Are you older than 60?
☐	☐	Are you currently taking medication for high blood pressure?

To further prepare for your exam:

YES	NO	
☐	☐	Do you have asthma?
☐	☐	Do you have a known allergy to X-ray contrast?

If you are at high risk we may prescribe medicine to be taken during the twelve hours before the injection to try to "block" an adverse reaction. We also use the newer family of contrast agents called "low osmolar" or "non-ionic". X-ray contrast has a long record of safety and effectiveness and these newer agents appear to have a lower incidence of reactions. However, serious reactions can still occur with low osmolar or non-ionic agents. If you have any questions, you are encouraged and expected to ask your CT radiographer or the radiologist.

Your signature on this form indicates that:

1. You read and understood the information provided in this form.
2. You have had a chance to ask questions.
3. You have received all information you desire concerning the procedure, and
4. You authorize and consent to the performance of the procedure.

_____ Patient Signature

_____ Print Patient Name

_____ Witness

_____ Date

FOR OFFICE USE ONLY

IV Contrast Administration:

Creatinine level checked: ☐ N/A ☐ Results: _____ mg/dl Ref Range 0.6 - 1.3 mg/dl

GFR: _____ml/min Est.Creatinine Clearance. Results. Obtained at: ☐iSTAT ☐SCHC lab ☐Other_____

Contrast: Iohexol 350 (Ominipaque) _____ml Iodixanol 320 (Visipaque) _____ml Flush _____ml

IV Gage: _____ Location: ☐RT ☐LT ☐Hand ☐Wrist ☐Forearm ☐AC ☐Existing

Complications: ☐No ☐Yes (Document in EMR) Caregiver Name:_____

Caregiver Signature:_____ Date:_____ Time:_____

Notes:_____