CT CONTRAST INJECTION FORM

Name: ______________________________________ Date: ______ Weight: ________ DOB: _________

Today you are scheduled to have an exam that requires you to have an injection of contrast material. Here at Advanced Imaging we use a nonionic IV contrast. This nonionic contrast has been proven to have less risk of adverse reactions than the ionic contrast previously used. Some common reactions which may occur are change in blood pressure, skin rash, hives. Other more severe reactions may occur but they are less common.

YES__NO__Do you have any food allergies? If yes, please list ____________________________________

YES__NO__Do you have drug allergies? If yes, please list____

YES__NO__Have you had iodinated contrast (X-ray/ CT dye) before?

YES___NO___Have you had a contrast reaction?

YES___NO___Do you take Glucophage____, Glucovance____, Metformin___, Avandia___

YES___NO___Any possibility of pregnancy? Are you Breastfeeding? Date of LMP_________

MEDICAL PROBLEMS:

YES___NO___Asthma/ Emphysema

YES___NO___Kidney (renal) disease

YES___NO___Dialysis

YES___NO___Diabetes

YES___NO___Hyperthyroidism

YES___NO___Multiple Myeloma/ Pheochromocytoma (tumors on adrenal glands)

YES___NO___History of cancer

YES___NO___Have you had radiation or chemotherapy? If yes, when____________

YES___NO___Sickle cell anemia or blood diseases

YES___NO___Seizures

List all Prior Surgeries:

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I have read the above information and am aware of the possibility of having a reaction from the contrast administered. I have asked any questions that may concern me and am giving my consent for the injection of intravenous contrast.

Patient Signature ____ Date ____________________

Technologist Signature ____ Date ____________________

Type of contrast:____________________

Time of injection:____________________

Reaction: NO____YES____

___Injector ___Hand

Volume used _____cc

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