CT SCREENING/CONTRAST CONSENT FORM

Name: ______________________ DOB: ____________ Height: ______ Weight: ______

Date: ____________ Referring Doctor: ______________________ Radiology #: ____________

PATIENT PLEASE ANSWER THE FOLLOWING QUESTIONS:

1) What complaints/symptoms led you to see the doctor?
____
____
Duration of Symptoms ______________________

2) **Allergies ______________________
____
____
Latex sensitivity/allergy Yes No

3) Allergy to Iodine Yes No

4) **Previous injection of X-Ray Dye for exams such as Angiogram, CT, IVP Yes No
   a) Any Problems after receiving dye? ____________
____
____

5) **Diabetes Yes No
Diabetic medication ______________________
How long have you been on medication? ________

6) **Kidney Disease Yes No
   a) Dialysis Yes No
   Next Dialysis ______________________
   b) Pheochromocytoma Yes No

7) Cardiac Problems Yes No

8) Stroke Yes No

9) **Personal Cancer History Yes No
   a) Type and date diagnosed ______________________
   b) Chemo Yes No
   Date of last treatment ______________________
   c) Radiation Yes No
   Date of last treatment ______________________

10) Multiple Myeloma Yes No

11) Weight loss Yes No
Amount ______ lbs. Time Frame ____________

12) Respiratory Problems Yes No
   a) Please circle: Asthma Emphysema Bronchitis
   b) History of smoking Yes No

13) Alcohol Consumption Yes No

14) Medications: ______________________
____
____
____

15) High Blood Pressure Yes No

16) Please list ALL previous surgeries and dates
____
____
____
____
____

17) Please list all tests done in past 6 months and where they were done

TEST	FACILITY
____________	____________
____________	____________
____________	____________
____________	____________
____________	____________

These particular items may not allow us to proceed with your examination

Patient Signature ______________________

BELOW LINE IS FOR TECHNOLOGIST'S USE ONLY!!

TECHNOLOGIST'S NOTES ONLY

Staff Signature ______________________

Patient Name (PRINT) ______________________________________

I understand contrast material will be injected. The indications for and risks of the procedure known as a CT SCAN were discussed with me. The risks were noted to include, but are not limited to, various types of allergic reactions to the intravenous contrast (such as iodinated contrast etc.). Most of these reactions are minor, although they can be severe at times. On rare occasions, inflammation or infection at the site can occur and other more remote risks or consequences may also arise.

I have been advised that if further explanation is desired, I may ask additional questions to the staff to include any supervising radiologists and my referring physician.

____ __________________
Signature of patient or legal guardian Date

____ __________________
Staff witness to signature Date

FEMALE PATIENTS:
☐ I AM PREGNANT
☐ I AM NOT PREGNANT / LMP ______________
I understand I will be receiving x-rays and hereby release all radiologists, respective staff and the facility thereof of any and all responsibility for any adverse reaction to myself and/or damage to my unborn fetus in the event I may be pregnant.

SIGNATURE ____