CT CYSTO CONTRAST FORM

SJRA
SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete
DOS: ____ / ____ / ____

PATIENT #: _____

PATIENT NAME: _____ _

DOB: _____ / _____ / _____ / AGE: _____ / SEX: _____

Your doctor has asked that your symptoms be evaluated with a CT (Computerized Tomography) study with iodinated contrast. This contrast is given by injection into the bladder and helps provide the radiologist with additional information that may not be available without intravenous contrast.

The contrast agent you will receive has been approved as safe and effective by the U.S. Food and Drug Administration (FDA).

As with any medication, a small chance exists that you may have a reaction to it. Minor and temporary reactions include pain at the injection site, nausea, headache, dizziness, itching, rash or hives. Rarely, a more serious allergic reaction may occur (including facial swelling, difficulty breathing, or low blood pressure) requiring treatment. The odds of an extremely severe reaction, including death, are very rare. Your chances of a reaction may be increased if you have had a previous allergic reaction to iodinated contrast, are allergic to other drugs or foods, have asthma.

Please answer the questions below.

Please list all allergies: _____

□ Yes □ No – Have you ever had an allergic reaction to CT (iodinated contrast)?

If yes, when and what happened? _____

FOR WOMEN: Are you breast feeding? □ Yes □ No

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form. By signing below I agree to the contrast injection.

Signature of Person Completing Form: _____ **Date:** _____

If Form Completed By Someone Other than the Patient (Print name): _____

Relationship: _____

TECHNOLOGIST USE ONLY

_____ cc Cystograffin, Lot/exp: _____ mixed with _____ cc Saline

Cystograffin/Saline mixture in bladder: _____ cc @ _____ am pm

Comments:_____ Steroid Prep: Y N

_____CT Technologist:_____

CT CYSTO HISTORY

SJRA
SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete
DOS: ____ / ____ / ____

PATIENT #: _____

PATIENT NAME: _____

DOB: _____ / _____ / _____ / AGE: _____ / SEX: _____

*** **Please answer the following questions about your medical history to the best of your ability. Our Radiologists and staff will use the information you provide to select the most appropriate imaging techniques and to interpret the examination in order to best serve you! If you have any questions, please do not hesitate to ask.** ***

Please describe the symptoms you are having that led to this test.
If you are in **PAIN**, please tell us where and which side (RIGHT/LEFT).

WEIGHT:

_____

_____

How long have you had these symptoms (days/weeks/months/years)?_____

Circle the level of pain you experience – 0 1 2 3 4 5 6 7 8 9 10 (most severe)

□ Yes □ No - Are you a current smoker?

□ Yes □ No - Did you smoke in the past? If you quit, how long ago? _____

□ Yes □ No - Have you ever had the following (please circle): COPD, emphysema, asthma, heart disease, aneurysm of the aorta, reflux or GERD (gastroesophageal reflux disease), hepatitis or liver disease, gallbladder disease or gallstones, pancreatitis, kidney stones, bowel obstruction, Crohn's disease, diverticulitis, colitis, endometriosis, fibroids, hernia.

□ Yes □ No - Have you had surgery of the heart, lungs, liver, gallbladder, pancreas, kidney, bladder, uterus, ovary, other (circle)?

If yes, please describe the surgery: _____

□ Yes □ No - Do you have a history of cancer of the lung, breast, colon, kidney, ovary, uterus, prostate, lymphoma (circle)?

If yes, when was it diagnosed (month/year)? _____

If yes, describe how your cancer was treated (radiation/gamma knife/proton/chemo/surgery) (circle)?

Please list approx. dates of treatment/procedures:

_____

Please list what/when/where you've had prior studies of this body part (MRI/CT/XRays/US/Angio/Nuclear Med)?

_____

FOR WOMEN: Date of last menstrual period: _____

Are you pregnant or think you could be? □ Yes □ No Have you had a hysterectomy? □ Yes □ No

Are you using any form of birth control? □ Yes □ No ---------- If yes, list: _____

TECHNOLOGIST USE ONLY

Comments: _____

_____

_____ CT Technologist: _____Ext:_____

I attest that the above information, including technologist's comments, is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date: _____

If Form Completed By Someone Other than the Patient (Print name):_____

Relationship: _____