CT 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 intravenous contrast. This contrast is given by injection into a vein 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). During the injection, you may experience a temporary warm sensation to "a really hot feeling". This is not an allergic reaction and is very common.

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, or have asthma.

Some patients with certain risk factors may also be at increased risk for a rare complication called Contrast Induced Nephropathy. As such, we screen higher risk patients by obtaining kidney function studies prior to contrast injection.

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? _____

□ Yes □ No Are you currently on dialysis?
□ Yes □ No Have you had a kidney transplant?
□ Yes □ No Have you ever had kidney surgery?
□ Yes □ No Have any kidney cancer or disease?
□ Yes □ No Do you have only one kidney?
□ Yes □ No Are you diabetic?

□ Yes □ No Do you take Metformin or any medication containing Metformin (for Diabetes)?
If you don't know, please list your diabetes medications: _____

_____

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

eGFR: _____ Date drawn: _____ Steroid Prep: Y N

IV Contrast: _____ cc of _____ Lot#_____@_____ am pm Exp: _____

Comments: _____

_____

CT BODY 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 CT 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: _____