



CT CONTRAST PATIENT PROFILE

PATIENT'S NAME Last	First

DATE OF STUDY	SEX	WEIGHT lbs.	DATE OF BIRTH	AGE
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DIAGNOSIS or SYMPTOMS (Reason for this exam)	Are you pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure LMP DATE <input style="width: 100px;" type="text"/>
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Have you ever had X-Ray Contrast (Dye) injected before? <input type="radio"/> Yes <input type="radio"/> No	Are you taking Glucophage (Metformin) <input type="radio"/> Yes <input type="radio"/> No Last dose taken: <input style="width: 100px;" type="text"/>
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In order to perform the exam your physician has requested, you will be given an injection of contrast containing iodine. The contrast allows the radiologist to better visualize the area of study.

Non-ionic iodine-related contrast media is considered quite safe. Any injection carries slight risk of harm including injury to a nerve, artery or vein, infection, or reaction to the contrast being injected. Occasionally, a patient will have a mild reaction to the contrast agent and develop sneezing or hives. Uncommonly a serious reaction occurs. The physicians and staff are trained to treat these reactions. Very rarely death has occurred related to contrast administration. A YES answer to any of the questions below does not mean that you will get a contrast reaction as the overwhelming majority of all patients do not.

If you have any questions about the contrast agent, risks, reactions, or the procedure itself, please ask the x-ray technologist or the physician.

Did you have any of the following reactions after a prior contrast injection?

<input type="checkbox"/> Rash	<input type="checkbox"/> Fainting	<input type="checkbox"/> Medical Treatment Required
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Flushing	<input type="checkbox"/> No Problems
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Other <input style="width: 100px;" type="text"/>

Do you have a History of any of the following?

<input type="checkbox"/> Asthma	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Severe Debilitation
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> High/Low Blood Pressure
<input type="checkbox"/> Hives	<input type="checkbox"/> Single Kidney	<input type="checkbox"/> Multiple Myeloma
<input type="checkbox"/> Sickle Cell Anemia	<input type="checkbox"/> Kidney Transplant	<input type="checkbox"/> None of These
	<input type="checkbox"/> Diabetes	

Food Allergies: Shellfish None Other

Drug Allergies: Iodine Antibiotics Other

I UNDERSTAND AND ACCEPT THE RISKS OF THE CONTRAST Yes No

Patient Signature	Date
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PROCEDURE DATA This Section to be Completed by Technologist/Nurse

<input type="checkbox"/> Signed consent on chart	IV Access Site Gauge _____ Location <input style="width: 100px;" type="text"/> 1st Attempt <input type="radio"/> Yes <input type="radio"/> No Other attempted sites <input style="width: 100px;" type="text"/>	Contrast Media <input style="width: 50px;" type="text"/> cc's LOCM using power injection	Premedicated <input type="checkbox"/> None <input type="checkbox"/> Steroids <input type="checkbox"/> Benadryl
<input type="checkbox"/> Order verified			

Patient Education

Provided To Patient Family Other Communication/Language Barriers - Explain

Complication Yes No Response Treatment

CONTRAST PATIENT PROFILE E1813 (Revised 12/16/2005)	Completed by: _____ Tech/Nurse Signature: _____
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