PATIENT INFO MEDICAL LABEL	OUTPATIENT CT QUESTIONNAIRE	Baptist HEALTH NEUROSCIENCE IMAGING CENTER

What symptoms are you having?____

____

Have you ever been diagnosed with any of the following?

1) Renal Failure Yes ______ No ______
2) Diabetic Yes ______ No ______
3) Cancer Yes ______ No ______
4) Heart disease Yes ______ No ______
5) Asthma Yes ______ No ______
6) High blood pressure Yes ______ No ______
7) Low blood pressure Yes ______ No ______

* If you are a Diabetic, please indicate if you take any of the following: **(GLUCOPHAGE / GLUCOVANCE / METAFORMIN / ADVANDAMET / METAGLIP)**

Are you allergic to any medicines that you are aware of?

Yes__________ No__________ What____

Have you ever had a CT Scan before?

Yes__________ No__________ What____

Previous Surgery: ____

____

AUTHORIZATION FOR CONTRAST INJECTION FOR ANY STUDY REQUIRING CONTRAST MATERIAL

______________ I HAVE HAD contrast material in the past and WAS NOT allergic to it at that time.

______________ I HAVE HAD contrast material in the past and WAS allergic to it.

______________ I HAVE NEVER HAD contrast material used for IVP's, CT Scans, Venograms, or Arteriograms.

Have you ever been injected with X-Ray dye for any of the following procedures?

1) IVP Yes ______ No ______
2) CT Scan Yes ______ No ______
3) Venogram Yes ______ No ______
4) Arteriogram Yes ______ No ______
5) Heart Catheterization Yes ______ No ______

I UNDERSTAND THAT THIS CONTRAST (LIKE MANY DRUGS) MAY CAUSE AN ALLERGIC REACTION.

I understand that my physician may have requested the use of a intravenous contrast media that will assist the radiologist in better distinguishing certain anatomy or abnormalities that would otherwise be difficult or impossible to see.

I understand that the procedure to be performed on me involves the use of x-rays, and possible inserting needles and iodine containing solutions (x-ray dye), which may enhance the diagnostic accuracy of the procedure.

I understand that I may be receiving an intravenous contrast media and/or oral contrast media to enhance the visibility of certain tissues. Possible side effects may include, but not limited to, pain or swelling at the site of injection, nausea, vomiting, a warm flushed feeling, potential allergic reaction including, but not limited to hives, wheezing, difficulty breathing, and in rare instances, anaphylactic shock (severe allergic reaction). The purpose, benefits, and complications of the contrast procedure will be explained to my satisfaction before any injection takes place.

I hereby consent to any measure necessary to correct complications which may occur. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee have been made to me concerning the results of this examination.

I confirm that the information I provided is complete and accurate to the best of my knowledge. I have read, understand, and consent to this CT examination.

______________________________ Patient's Signature

______________________________ Parent/ Guardian/ Authorized Person for minor

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EDUCATION AND PREPARATION OF THE PATIENT FOR PROCEDURE	TIME OUT BRIEFING: VERIFY PRIOR TO INJECTION PROCEDURE	
☐ PROCEDURE DISCUSSED WITH PATIENT AND ALL QUESTIONS ANSWERED	☐ CORRECT PATIENT	☐ ALL STERILE SOLUTIONS LABELED
☐ PATIENT UNDERSTANDS PROCESS INVOLVED AND ABLE TO PERFORM STUDY	☐ CORRECT SIDE/SITE	☐ CORRECT EQUIPMENT/SUPPLIES
☐ PATIENT HAS BEEN FASTING FOR THE APPROPRIATE LENGTH OF TIME	☐ CORRECT PERMIT/PROCEDURE	☐ CORRECT LABS/RADIOLOGY FILMS
☐ PATIENT HAS TAKEN THE APPROPRIATE PREP FOR PROCEDURE	☐ CORRECT PATIENT POSITION	

Contrast type: ______________ Injection site: ______________

Contrast Volume: ______________ Reaction: ______________

Injection time: ______________ Radiologist: ______________

Tech Signature:______________________________