Date: ____

Reason for Exam: ____

List all surgeries: ____

Prior exams: ____

List all existing medical problems: ____

____

Are you a Diabetic: ☐ Yes ☐ No. Do you take oral medication for diabetes: ☐ Yes ☐ No

If yes: Drug Name:____________________

☐ Patient given contrast discharge instructions.

Do you have a history of:

Allergies (x ray contrast (dye), latex, medications)	☐ No	☐ Yes	If yes, ______________________
Have you ever had an x ray contrast (dye) Injection:	☐ No	☐ Yes	If yes, ______________________

Do you have a history of:

Cancer:	☐ No	☐ Yes	If yes, ______________________
Lung Disease:	☐ No	☐ Yes	If yes, ______________________
Heart Disease:	☐ No	☐ Yes	If yes, ______________________
Blood Disorder:	☐ No	☐ Yes	If yes, ______________________
Kidney Disease: (Renal insufficiency / Reduced Renal Function)	☐ No	☐ Yes	If yes, lab required prior to procedure
Are you taking a blood thinner currently:	☐ No	☐ Yes	If yes, ______________________

Date of last renal function labs: __________ BUN ______(5-21) Creatinine ______(0.7-1.5) GFR____________

Are you possibly pregnant: ☐ No ☐ Yes

Type of IV contrast used: ____________________ Amount: ______________

Lot # ____________________ Expiration Date: ____________________

Injection Site:________________________ Attempts: ______ Gauge: ______ Initials: ______

Patient Signature:______________________________ Date: __________ Time: __________

Technologist or Nurse Signature: ______________________________ Date: __________ Time: __________

OLOLSH RAD013 (7/21)

CT AND/OR IV CONTRAST SCREENING

Patient Label