College Park Imaging fax 913-601-3827 CT Screening Form

Name: ______________________________ Patient ID #: ________________ Appt. Date & Time______________________________

****EXAM:** ____ DX/Reason: ____

WT: _______ HT: _______ Age: _________ DOB: ___/___/___ Gender:______________ Patient Phone__________________________

Attempted Call: __________ Physician: _____________________________ Prior Exams: ____________________________________

Technologist Notes:

Please mark YES or NO if this pertains to the patient:

YES / NO Any previous study with injected contrast?
YES / NO Allergy to latex or rubber products
YES / NO **Allergies/Reactions**
Specify: ___________________________
YES / NO **Food Allergies**
Specify: ___________________________
YES / NO Asthma or Pulmonary disease
YES / NO **Hypertension**
If yes, do you take medications for hypertension YES/NO
YES / NO **Diabetes**
If yes, please circle Insulin Glucophage/Metformin Other Oral Medicine
YES / NO **History of Renal disease**
YES / NO **Kidney Cancer**
YES / NO **One kidney**
YES / NO **Surgery to kidneys**
YES / NO **Dialysis**
YES / NO **Kidney transplant**
YES / NO Is there a possibility of you being pregnant?
Required on all female patients between 12-50 years old
Date of last menstrual period: ____/____/____

YES / NO Do you smoke?
If yes, how long?______ How many packs a day?______
YES / NO Blood disorder (Sickle cell, hepatitis, AIDS)
YES / NO Pheochromocytoma (tumor of adrenal gland)
YES / NO Neurological problem (seizure, stroke, tumor)
YES / NO Multiple myeloma (cancer of bone marrow)
YES / NO History of Myasthenia Gravis
YES / NO History of Thyrotoxicosis
YES / NO History of Dysproteinemias
YES / NO Personal history of cancer
Type:______________________________
Type: ______________________________
YES / NO History of Chemotherapy or Radiation
YES / NO PET scan imaging
When/Where: ______________________
YES / NO Heart disease (MI, Angina, CHF, Arrhythmias)
YES / NO Pacemaker, pacemaker wires, heart valve or coronary stents***
******If YES patient CANNOT have a Cardiac Score***

Recent Trauma
Date: __________ **Description:** ____
____

Surgeries: ____
____

Medications: ____
____

If patient was on Glucophage/Metformin did they receive aftercare instructions?	☐ YES ☐ NO ________________Tech Initials
If patient was pre-medicated; verify patient followed pre-medication instructions	☐ YES ☐ NO ________________Tech Initials

Date of labs: ___/___/___ (within 30 days)	Creatinine	GFR
	-eGFR < 45, consult the radiologist. Obtain Consent	GFR consent signed:

IV Contrast:	Lot #	Dosage:
Injection Site: Needle guage:	Oral Contrast:	Injected by: Attempts:

Signature of Patient: ____ Date __________

Signature of Parent or Guardian: ____ Date __________
If guardian, relationship to the patient: __________________________________

Technologist Signature: ____ Date ___________

College Park Family Care Center
Imaging Center

CT IV Contrast consent

Patient's Name: ____

I hereby authorize the Radiologist and assistants (including responsible imaging center personnel) as are necessary to perform the radiological examination indicated below:
CT scan of:
( )Head ( ) Chest ( )Abdomen ( )Pelvis ( )Neck ( )Extremities ( )Other:________________

And any addition to treatments and/or procedures as is considered therapeutically necessary, on the basis of the finding during the course of this examination.

Your CT examination may include images made after the injection of iodine contrast (Optiray). Optiray injection may allow the Radiologist to identify additional details about your conditions which might not be apparent without the use of Optiray contrast.

When this contrast is injected intravenously, most patients will notice a warm sensation, a metal taste in the mouth and some become nauseated briefly. This is a normal side effect. As with any medications a patient might be allergic to this contrast. The most common allergic reaction is Hives. As with any medication reactions can occur such as asthma, swelling of the vocal cords, throat and even, rarely shock may occur. A physician is immediately available to treat any undesirable reactions that may occur. College Park asks that you sign this conset form agreeing to the injection of contrast for the CT procedure.

Have you ever experienced an adverse reaction to CT contrast agent or iodine YES/NO
If Yes, please explain: ____

If you wish to discuss the examination further with the Radiologist, please inform the technologist.

I understand I have the right to refuse the use of contrast agent containing Iodine (Optiray) and still undergo the CT scan, although it may limit the usefulness of this scan. I have read and understand the above explanations and choices and give my consent to the examination.

Patient Signature: ____ Date: ______________________

If guardian, relationship to patient: ____

Technologist Signature: ____

GFR Consent for Procedure and Treatment

I authorize Dr. ____________________________ and whomever he/and or she designates as assistant(s) to perform a CT________________________ with contrast upon myself.

Risks included but not limited to: Allergic reaction to contrast, possible development of Nephrogenic Systemic Fibrosis (NSF), multi system organ failure, renal failure and dialysis.

And if any unforeseen condition becomes apparent in the course of the procedure which would require an extension of the original procedures or a different procedure from that described above, I authorize the above physician and his/her assistants and associates to perform such procedures as they, in the exercise of professional judgment, deem necessary. I also consent to the administration of medications as necessary. The nature and purpose of the procedure, the risks and benefits of the procedure, and the risks and benefits of not receiving or undergoing the procedure have been fully explained to me.

I certify that I have read and fully understand the above consent for the procedure listed, and agree to such procedure that has been adequately explained to me by the physician and/or staff. I have all the information I desire concerning the procedure and that all blanks were filled in before I signed.

Patient's signature: ____ Date: ____

Technologist signature: ____ Date: ____