CT Patient Screening Form - Part A

CT SERVICES PATIENT INFORMATION

Patient Name: ______________________ Date of Exam: ______________________
Date of Birth: ______________________ Exam Ordered: ______________________
Medical Record #: ______________________ Referring Physician/Specialty: ______________________
Patient Stated Weight: ______________________ Diagnosis: ______________________
Facility Name: ______________________ Pt. Address: ______________________
Patient's Zip Code: ______________________

Reason for Exam: ______________________

PATIENT HISTORY

All "Yes" single and double asterisked (* or **) are to be referred to the radiologist. Pregnancy requires signed informed consent.

**** Pregnant**	❑ Yes	❑ No
*** Diabetes**	❑ Yes	❑ No
*** Oral Diabetic Medications** (Glucophage, Metformin, etc.)	❑ Yes	❑ No
*** Allergies to IV dye or latex**	❑ Yes	❑ No
*** Breast Feeding**	❑ Yes	❑ No
*** Multiple Myeloma**	❑ Yes	❑ No
*** Renal Dialysis/Renal Failure/Insufficiency**	❑ Yes	❑ No
*** Sickle Cell Anemia**	❑ Yes	❑ No
*** Pacemaker**	❑ Yes	❑ No
*** Infusion Pump**	❑ Yes	❑ No
*** Neurostimulator**	❑ Yes	❑ No
*** Implanted or External Medical Devices**	❑ Yes	❑ No
Asthma/COPD/Emphysema	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
Irregular Heartbeat	❑ Yes	❑ No

History of Cancer	❑ Yes	❑ No
What Type ______________________		
Chemotherapy ______ **Radiation** ______		
Previous Stroke	❑ Yes	❑ No
Metallic Implant/Prosthesis	❑ Yes	❑ No
Orthopedic Devices	❑ Yes	❑ No
Surgical Clips	❑ Yes	❑ No
Epilepsy (Seizures)	❑ Yes	❑ No
Uncooperative or Disoriented	❑ Yes	❑ No
Claustrophobia	❑ Yes	❑ No
Unable to Hold Still	❑ Yes	❑ No
Difficulty Swallowing	❑ Yes	❑ No
Removable Dental Work	❑ Yes	❑ No
Braces	❑ Yes	❑ No

History of Falls ❑ Yes ❑ No **If yes, most recent fall date:** ______________________

Any history with an ** or * approved by Radiologist/Supervising Physician? **Approved by:** ______________________

Date: ___________ **Time:** ___________

Please list previous surgeries: ______________________

____

Check Box below if a <u>previous</u> scan completed was similar to body part being examined today

			If yes Specify Area
Previous MRI	❑ Yes	❑ No	______________________
Previous CT	❑ Yes	❑ No	______________________
Previous PET/PETCT	❑ Yes	❑ No	______________________
Previous X-Rays	❑ Yes	❑ No	______________________

Factors such as patients weight, body habitus and scan type may determine if the scan can be performed.

I understand the risk of having an x-ray while pregnant and I do not believe I am pregnant. Initial: _______ Date: __________

Signature of Patient: ______________________ **Date:** ___________
(*Parent or Guardian if patient is a Minor or Incapacitated*)

I have reviewed this information with the patient or their legal guardian, power of attorney, next of kin, etc.

Interviewer's Signature: ______________________ **Date:** ___________

Tech Signature: ______________________ **Date:** ___________

CT Patient Screening Form - Part B

Patient Name:____________ **Date of Birth:**____________ **Date:**________

CONTRAST

Your physician or radiologist may deem it necessary for you to have an IV injection of contrast liquid containing iodine to improve the quality of your CT examination. Although iodine contrast agents have been used safely in millions of patients, minor reactions (principally headache, itching, hives, or nausea) may occur. More serious complications, including cardiac, renal and respiratory problems as well as shock and fatalities, are extremely rare but possible. If you take medication for diabetes such as Glucophage, Glucovance, Actos Plus or Metformin, you understand that you must stop taking it at the time of or prior to your exam and **you must contact your physician** for instructions before resuming your medication.

I have read and understand the above information, and have had my questions answered. I agree to have the CT procedure and injection of contrast if deemed necessary.

History of previous reaction ❑ Yes ❑ No

If Yes, Explain ____________

Patient Stated Weight ________

BUN ________ Account Range: High ____ Low ____

CREATININE ________ Account Range: High ____ Low ____

eGFR ________ (Range: Low = 30 High = >60)

Signature of Patient ____________ Date ________

(Parent or Guardian if Minor or Incapacitated)

Post Injection Check: Time:________

Has patient's condition changed since injection? No ____ Yes ____

If yes, specify change: ____________

I.V. Contrast Name ________

Amount ________

Lot #________

Exp. Date________

Injection Site ________

Device Used ________

Rate of Admin.________

Tech Initials ________

Oral Contrast Name________

Amount ________

Lot #________

Exp. Date________

Administered By: ________

Title:________

Are you allergic to any medications, seafood, or shellfish?

❑ Yes ❑ No If Yes, please list:

1 ________ 3 ________

2 ________ 4 ________

❑ Patient unaware of current medications ❑ Patient not on any medications

List any medication(s) the patient has taken today and all current medications:

(Include over the counter, ointments, herbals, vitamins, birth control, etc.)

1 ________ 6 ________

2 ________ 7 ________

3 ________ 8 ________

4 ________ 9 ________

5 ________ 10 ________

Barriers to Learning ❑Yes ❑No

Type:	Intervention:
❑Language	❑Interpreter Used
❑Hearing	❑Repeat Questions
❑Other	❑Family/Significant Other

If patient has self-medicated for anxiety/claustrophobia specifically for today's procedure (not routine medications), do they have a driver? ❑ Yes ❑ No

Prior to release, patient was assessed and found impaired? ❑ Yes ❑ No If yes, Supervising Physician notified? ❑ Yes ❑ No
If patient refuses further assessment, notify Supervising Physician and Alliance personnel to follow policy #5023.

Comments:____________

MINOR MODIFICATIONS BY RADIOLOGIST/PHYSICIAN ❑ Yes ❑ No

Original Exam Order Changed to:________ **Changed by:**________ **Date/Time:** ________

Tech Signature: ________ **Read Back** ❑ Yes ❑ No **Physician Signature:** ________

Post Injection Instructions given (applicable to all patients who receive an injection). ❑ **Yes** ❑ **No** ❑ **N/A**
Patient notified of rights and opportunity to "Speak up" with questions or concerns. ❑ **Yes** ❑ **No**
Handoff Report given to next provider of care. Medication list provided if applicable. ❑ **Yes** ❑ **No** ❑ **N/A**

Interviewer Signature ____________

Title: ____________ **Date:** ________

Tech Comments____________