CT CORONARY QUESTIONARIE

NAME____________________________ AGE________ SEX__________

FAMILY DOCTOR____________________ REFERRING DOCTOR____________________

REASON YOU ARE HERE:____

MEDICATIONS:____

MEDICATION ALLERGIES:_______________________________________

MEDICAL HISTORY:

HEART TROUBLE DIABETES ARTHRITIS HIGH BLOOD PRESSURE
THYROID TROUBLE ASTHMA EMPHYSEMA HIGH CHOLESTEROL
HEPATITIS STROKE CANCER STOMACH TROUBLE

SURGERIES:____

PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU ARE EXPERIENCING:

WEAKNESS CHEST PAIN FEVER ABDOMINAL PAIN
COUGH CONSTIPATION RASH WEIGHT LOSS/ GAIN
SHORTNESS OF BREATH DIARRHEA NAUSEA BLACK /BLOODY STOOL
PALPITATIONS VOMITING SWELLING TROUBLE URINATING
HEADACHES NUMBNESS DIZZINESS INDIGESTION
TINGLING VISION CHANGES HEART BURN JOINT PAIN

OCCUPATION:____

HAVE YOU EVER USED TOBACCO? YES NO TYPE: CIGARETTES CIGAR PIPE CHEW DIP

AMOUNT PER DAY______ HOW LONG?______ IF STOPPED WHEN____________

ALCOHOL USE: YES NO AMOUNT:_______ CAFFEINE USE: YES NO AMOUNT:_______

ARE YOU ALLERGIC TO IODINE: YES NO LAST MENSTRAL CYCLE:____________

TECH INFORMATION:

PT WEIGHT:_______ PT HEIGHT: _______ TECHNOLOGIST:____________________

PRE SCREENING INFORMATION:

BLOOD PRESSURE: ______________

HEART RATE:_________________

02 SAT:______________________

POST SCREENING INFORMATION:

BLOOD PRESSURE: ______________

HEART RATE:_________________

02 SAT:______________________

PATIENT SIGNATURE:______________________________ DATE:______________

Patient Sticker

Pregnancy Release Form

It is recognized that ionizing radiation can be harmful to a fetus or that the effects of a magnetic field has been undetermined as of yet. It is the policy of Imaging Center that women who are pregnant or suspect that they are pregnant should not have an exam that utilizes ionizing radiation or magnetic fields unless the referring physician and/or radiologist determine the exam are medically necessary. Imaging Center requires confirmation of pregnancy/non pregnancy for women of childbearing age prior to performing any radiographic procedure involving ionizing radiation or magnetic field. Childbearing age is considered to be between 10-60 years of age.

PATIENT: Please check and initial your pregnancy status:

- ______________I am not pregnant ____________(Patients Initials)
- ______________I am ________weeks pregnant _________(Patients Initials)
- ______________I am unsure of my pregnancy status ________(Patients Initials)

Pregnancy may be confirmed with blood/urine test at the patients' expense. I understand that the urine pregnancy test that the Imaging Center utilizes is not 100% accurate, and if the test is performed within 21 days of conception the results may not be accurate. **If you are pregnant or suspect that you may be pregnant, your options are as follows:**

UNCLEAR PREGNANCY STATUS:

________I have decided to reschedule the exam/procedure until my pregnancy status is confirmed the Imaging Center personnel will notify my physician of the delay of my exam.

_______I am unsure of my pregnancy status and have decided to decline a pregnancy test. I have decided to have the exam with ionizing radiation and have opted to be shielded. I understand that the shield is not 100% protective against ionizing radiation, and for some procedures requiring images of the pelvis, shielding is not possible.

________**I have had a pregnancy test and the results indicate**
____I am not pregnant________(Patients Initials)
____I am pregnant_________(Patients Initials)

POSITIVE PREGNACY STATUS:

At this time **I am pregnant** and I (have):
_____Consented to undergo the exam/procedure________ (Patients Initials)
_____Decline the exam/procedure __________ (Patients Initials)

By Signing below, I agree that the above statements are true and hereby release the Imaging Center from any complications that may occur from exposure to radiation or a magnetic field and assume responsibility for my decision to undergo the procedure/exam.

______________________________ ______________________
Patient/Legal Representative Signature Date/Time

______________________________ ______________________
Imaging Center Staff Date/Time

Tech Only: Pt Shielded: YES /NO Tech Initials ________

FORM: RAD1009A
Effective Date:
Revised Date:

Patient Sticker

Contrast Media Authorization

Procedure:________________________________

Your doctor has requested an imaging procedure that requires the use of radiographic contrast media which will be injected into your blood stream and allows various internal body parts and systems to be seen during imaging. This contrast solution is associated with potential risks. Most patients experience no adverse or unusual effects from contrast use. An evaluation of your responses to the questions on the "Patient Information Sheet" will help us determine whether you may have a higher risk of a reaction. These questions help determine whether you may be allergic to contrast or need additional interventions. Please inform the technologist if you have ever been allergic to, become sick from, or developed a skin rash from medication containing iodine. Even if you do not fall into this category, you may still experience a reaction.

You may experience a temporary warm sensation from head to toe, nausea and vomiting, or a strange taste in your mouth. These sensations do not require treatment. Allergic-type reactions, although rare, may include itching, hives, swelling of the lips and eyes, sneezing, shortness of breath. The most severe reactions, which are extremely rare, may include shock, kidney failure, and cardiac arrest.

I feel that I have adequate knowledge and sufficient time upon which to base my consent to the procedure and the use of contrast media. I have had an opportunity to ask questions, and they have been answered to my satisfaction. I herein consent to the procedure and use of contrast media.

____________________________ ____________ __________
Signature of patient or representative — Date — Time

____________________________ ________________________
Relationship to patient — Interpreter (if utilized)

If unable to obtain patient authorization, the referring physician gives approval to proceed with IV contrast

____________________________ ________________________
Physician Signature — Date/Time

____
Witness

CT, IVP PROCEDURE QUESTIONNAIRE

PATIENT NAME______________________________ PATIENT #__________

EXAM ORDERED____________________ REFERRING PHYSICIAN________________

SYMPTOMS____________________ AGE____________________

SEX M F

CIRCLE ONE

Y N ASTHMA/ HAYFEVER
Y N CONGESTIVE HEART FAILURE
Y N DIABETES
Y N DO YOU TAKE GLUCOPHAGE, METFORMIN, GLUCOVANCE OR AVANDAMET ?
Y N FIBRILLATION OR HEART FLUTTER
Y N HIGH BLOOD PRESSURE
Y N HEART DISEASE/ PROBLEMS
Y N GENERALIZED SEVERE DEBILITATION
Y N HYPERTENSIVE RENAL DISEASE (KIDNEY)
Y N MULTIPLE MYLEOMA
Y N RENAL FAILURE (KIDNEY)
Y N RESPIRATORY FAILURE
Y N SICKLE CELL DISEASE
Y N STROKE
Y N ANGINA(SEVERE PAIN IN THE CHEST)
Y N ARE YOU NURSING A BABY?
Y N HAVE YOU HAD A HYSTERECTOMY?

IF YES DESCRIBE:______________________________

PLEASE LIST ALL ALLERGIES BELOW

1.__________ 3.__________

2.__________ 4.__________

PLEASE LIST ALL MEDICATIONS

1.__________ 3.__________

2.__________ 4.__________

PLEASE LIST ALL SURGERIES

1.__________ 3.__________

2.__________ 4.__________

HAVE YOU HAD PREVIOUS CT, XRAYS, OR MRI RELATED TO THIS PROBLEM?
IF YES, WHEN & WHERE: CT____________________
XRAYS__________ MRI__________

PATIENT'S INITIALS__________ LAST MENSTRUAL PERIOD__________

TECHNOLOGIST USE ONLY:
Patient Status: Debilitated or Ambulatory BP:__________ WT:__________
Was the patient pre-medicated YES NO Fasting? YES NO
Contrast injected:__________ Lot#__________ Exp Date:__________
Volume:__________ml Time:__________ Injection Site:__________
Technologist __________ Radiologist:__________
Additional Notes:____________________

Office Use
Received by:________
Entered by:__________

PATIENT PROFILE

PATIENT INFORMATION

Name: ______________________________

Address: ______________________________

City: ____________State: ______ Zip: _______

Home Phone: ______________________________

Work Phone: ______________________________

Cell Phone: ______________________________

EMAIL: ______________________________

Patient ID#: __________ Sex: [ ]M [ ]F

Date of Birth: ______________________________

Social Security #: ______________________________

Marital Status: [ ] Married [ ] Single

Referring Physician: ______________________________

Primary Care Physician: ______________________________

PATIENT EMPLOYMENT

[ ] Employed [ ] Retired [ ] Not Employed

Employer: ______________________________

Phone: ______________________________

EMERGENCY CONTACTS (NAME & PHONE)

(1)______________________________

(2)______________________________

(3)______________________________

RESPONSIBLE PARTY (Must complete if responsible party is other than the insured or patient.)

[ ] Same as Patient [ ] Same as Insured

Name: ______________________________

Address: ______________________________

City, State, & Zip: ______________________________

Drivers License #____________________State_____

Relation to Patient: ______________________________

Employer: ______________________________

Phone: ______________________________

Date of Birth: ______________________________

Social Security#: ______________________________

PRIMARY INSURANCE (Must complete in its entirety in order for us to file with your insurance.)

Name of Insured: ______________________________

Name of Insurance Company: ______________________________

Insurance Phone #: ______________________________

Insured Employer: ______________________________

Relation to Patient: ______________________________

Insured SS#: ______________________________

Policy Group #: ______________________________

Insured Date of Birth: ______________________________

IS THE PATIENT COVERED UNDER ANY OTHER INSURANCE? YES / NO (IF YES, PLESE COMPLETE BELOW.)

SECONDARY INSURANCE

Name of Insured: ______________________________

Name of Insurance Company: ______________________________

Insurance Phone #: ______________________________

Insured Employer: ______________________________

Relation to Patient: ______________________________

Insured SS#: ______________________________

Policy Group #: ______________________________

Insured Date of Birth: ______________________________

I understand that this form must be completed in its entirety. I understand that if all of the above information is not completed, a claim may not be able to be filed to my insurance company; therefore, making me fully responsible for any charges incurred.

Please tell us how you were referred to our office: ___friend ___doctor ___location ___internet ___insurance ___other:

Patient/Responsibility Party Signature: ______________________________