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:____

CONTRAST CONSENT FORM

INFORMED CONSENT FOR INJECTION OF INTRAVASCULAR X- RAY CONTRAST AGENT FOR SPECIAL X-RAY STUDIES

ARE YOU ALLERGIC TO DYE (USED FOR KIDNEY AND/ OR HEART STUDIES)? YES NO

HAVE YOU HAD X – RAYS OF ANY TYPE RECENTLY? YES NO

PROCEDURE DESCRIPTION

THIS IS TO VERIFY THAT YOUR DOCTOR HAS REQUESTED A SPECIAL X-RAY STUDY FOR YOU THAT IS PERFORMED BY A RADIOLOGIST AND REQUIRES THAT A SOLUTION IS INJECTED INTO YOUR VEIN TO HELP DIAGNOSE POSSIBLE PROBLEMS. THE SOLUTION IS CALLED X- RAY CONTRAST.

RISKS

MOST PATIENTS EXPERIENCE NO UNUSUAL SIDE EFFECTS OR COMPLICATIONS FROM THE X- RAY CONTRAST INJECTION. HOWEVER, AS WITH ANY MEDICAL PROCEDURE SOME RISK IS INVOLVED. DURING INJECTION OF THE X-RAY CONTRAST, YOU MAY FEEL A WARM SENSATION OR NAUSEA. SOME PATIENTS HAVE AN ALLERGIC TYPE REACTION WITH ITCHING AND/OR HIVES, SWELLING OF THE EYES AND LIPS, SNEEZING, OR DIFFICULTY BREATHING. MEDICATION WILL BE ADMINISTERED TO YOU IF THESE CONDITIONS OCCUR.

IN RARE INSTANCES, MORE SERIOUS COMPLICATIONS OCCUR, INCLUDING SHOCK, KIDNEY FAILURE, AND CARDIAC ARREST. SHOULD ANY OF THESE REACTIONS OCCUR, IMMEDIATE MEDICAL ATTENTION MIGHT BE NECESSARY, INCLUDING POSSIBLE SURGERY. ALTHOUGH NOT LIKELY, PERMANENT DAMAGE TO YOUR HEALTH IS POSSIBLE. FATAL COMPLICATIONS ARE RARE WITH THIS PROCEDURE.

YOUR DOCTOR IS AWARE OF THESE POSSIBLE COMPLICATIONS, BUT HAS DETERMINED THAT THE DIAGNOSTIC INFORMATION PROVIDED BY THIS PROCEDURE OUTWEIGHS THE RISKS INVOLVED.

COST INFORMATION

THERE ARE TWO TYPES OF X-RAY CONTRAST AGENTS AVAILABLE FOR THE PROCEDURE. THIS FIRST TYPE IS IONIC (LESS EXPENSIVE) AND THE SECOND IS NONIONIC (MORE EXPENSIVE, WITH FEWER ADVERSE SIDE EFFECTS). THE U.S. FOOD AND DRUG ADMINISTRATION HAVE APPROVED BOTH TYPES. HOWEVER, WE USE ONLY THE NON-IONIC AGENT FOR THE TYPE OF PROCEDURE YOUR DOCTOR HAS REQUESTED. THIS IS BECAUSE OF THE DECREASED RISK OF ANY ADVERSE REACTION, AND THE INCREASED SAFETY AND COMFORT FROM THE NONIONIC CONTRAST. YOUR HEALTH INSURANCE POLICY MAY NOT COVER THE ADDED COST OF THE NONIONIC AGENT, IN WHICH CASE, THE COST COULD BE YOUR RESPONSIBILITY.

PATIENT CONSENT

MY DOCTOR HAS DISCUSSED WITH ME THE NEED FOR THE PROCEDURE DESCRIBED AND ITS IMPORTANCE FOR MY CARE. I HAVE BEEN GIVEN AN OPPORTUNITY TO ASK PERTINENT QUESTIONS AND ALL QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I THEREFORE AUTHORIZE 1960 DIGITAL IMAGING/I IMAGING AND WHOMEVER THEY MAY DESIGNATE AS THEIR AGENTS OR ASSISTANTS TO PERFORM THE PROCEDURE DESCRIBED ABOVE USING NONIONIC CONTRAST AGENTS, AND RENDER ANY FURTHER CARE AND TREATMENT WHICH MAY BECOME NECESSARY IN THE COURSE OF HAVING THIS PROCEDURE.

________________________________ ________________________________

PATIENT SIGNATURE WITNESS SIGNATURE

_________________________ TIME

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: