Abington Memorial Hospital

Patient Questionnaire

For Administration of IV Contrast Material

Please provide us with the following information. This will help us perform and interpret the examination safely and appropriately.

Patient Name: _____ **IP OP ETC**

Height_____ Weight_____ <u>Needed for Proper Protocol selection</u>

Type of Cat Scan: (circle) Sinus Head Neck Chest Abdomen Pelvis Other_____

Reason for exam: _____

Other than oral contrast, when did you last eat or drink? _____

Please answer each question YES or NO	**YES**	**NO**
Do you have prior outside x-rays or CT scans that are relevant to the exam being performed today?		
Have you brought the outside institution films with you?		
Do you have any of the following medical problems?	**YES**	**NO**
Kidney failure/ poor kidney function		
Asthma		
Diabetes		
Hyperuricemia (High Uric Acid)		
Heart disease on diuretics		
<u>Do you take any medications containing metformin?</u> Metformin, Metaglip, Glucovance, Glucophage, Glucophage XR, Fortamet, Riomet, Actoplus Met, Avandamet ,Glumetza, Janumet, Prandimen Riomet, Linagliglitin, Saxagliptin		
Do you have allergies to any medications? If YES, please specify.		
Have you ever had x-ray dye (CT, IVP, catheterization)?		
Are you allergic to x-ray dye? If YES, please specify.		
If female, is there any chance that you are pregnant?		
When was your last menstrual period?_____		

Patient's Signature_____Date_____

To Be Completed by Technologist

Risk Factors for Contrast

	No	Yes & ordered with	Yes & contrast not specified
Advanced age (>70 years of age)			
Cardiac History (If YES, specify):			
Asthma			

	No	Yes	
Diabetes			
Multiple myeloma			
Kidney failure/disease			
Hyperuricemia (High Uric Acid)			
Heart disease on diuretics			
Sickle Cell Disease in Crisis			
Is the patient taking any of these medications containing metformin? **Metaglip, Glucovance, Glucophage, Glucophage XR, Fortamet, Riomet, Actoplus Met, Avandamet**, **Glumetza, Janumet, Prandiment, Riomet, Linagliglitin, Saxagliptin**			
BUN / creatinine if YES _____			

	No	Yes
Risk Factors and no BUN/Creat		
Risk Factors and Creat >= 1.5		

	No	Yes
Allergy to Contrast		
Premeds given (if necessary), specify:		
Chance of pregnancy? LMP: _____		
Breast feeding?		

Outpatient - Metformin Information sheet given to _____ by _____
ETC, SPU or IP Metformin Note placed in Medical Record YES or NO
and Name of Nurse notified: _____ Date: _____ Time: _____ Initials: ____

Other:

If yes to any answer in the right hand column and contrast indicated approval must be obtained.

Contrast approved by (give name) Radiologist_____or by Clinician_____.
Technologist Initials_____

Contrast Injection **IP OP ETC**

Volume_____ ML Type Omni 300 Omni 350 Visipaque 320 Location of IV access_____

Flow Rate 1 ml/s 1.5 ml/s 1.8ml/s 2ml/s 2.5ml/s 3ml/s 4ml/s 5ml/s other _____

Injecting Technologist Initials_____ Date_____