



CT PATIENT SCREENING FORM

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: _____ Ht: _____ Wt: _____

Ordering Physician: _____ Procedure: _____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

What complaint/symptom led you to see the doctor?

How long have you had your symptoms? _____

Are you sensitive or allergic to Latex? YES NO

**** Do you have Diabetes?** YES NO

If YES, please indicate the name of medication you are taking? _____

Date and Time of Last Dose: _____

**** Do you have a history of kidney disease?** YES NO

If YES, are you on dialysis? YES NO Next scheduled dialysis: _____

**** Do you have a history of pheochromocytoma (adrenal gland tumor)?** _____

**** Do you have a history of Cancer?** _____ Type & Date diagnosed: _____

Chemo therapy: YES NO Date of last treatment: _____

Radiation: YES NO Date of last treatment: _____

**** Please indicate any allergies:** _____

Are you allergic to IODINE? YES NO

**** Have you previously been injected with x-ray dye for exams, such as Angiograms, CT or IVP's?** YES NO

If YES, please indicate any problems after receiving the dye _____

Do you suffer from cardiac problems? YES NO

Do you have a history of high blood pressure? YES NO

Do you have a history of stroke? YES NO

Do you have multiple myeloma? YES NO

Do you have sickle cell anemia? YES NO

Do you have any respiratory problem? YES NO Please indicate: _____

****THESE PARTICULAR ITEMS MAY NOT ALLOW US TO PROCEED WITH THE EXAMINATION**

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Please list medications currently being taken: _____

Please list all previous surgeries and dates: _____

FOR FEMALE PATIENTS ONLY

Date of last menstrual period: _____

YES NO Are you pregnant or suspect you may be pregnant?

YES NO Are you breast-feeding?

YES NO Diaphragm, IUD, Pessary? Other types of birth control: _____

I have informed the technologist that I am NOT pregnant at this time. PT. INITIALS _____

I understand I will be receiving x-rays and hereby release all radiologists, respective staff and the facility thereof of any and all responsibility for any adverse reaction to myself and/or my unborn fetus in the event I am pregnant.

SIGNATURE: _____ **DATE:** _____

I understand I will be receiving x-rays and hereby release all radiologists, respective staff and the facility thereof, of any and all responsibility for any adverse reaction to myself.

In the event contrast material is injected, the indications for and risk of the procedure known as CT SCAN were discussed with me. The risks were noted to include, but are not limited to, various types of allergic reactions to intravenous contrast (such as iodinated contrast, etc). Most of these reactions are minor; although they can be severe at times. On rare occasions, inflammation or infection at the site can occur and other more remote risks or consequences may also arrive.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form

Patient/Guardian Signature: _____ **Date:** _____

MD/RT Signature: _____ **Date:** _____

Print MD/RT Name: _____