

CT PATIENT SCREENING FORM

Name: _____ Date: _____

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

PATIENT HISTORY

YES NO Do you have any allergies (medication, food, latex)? If yes, please list _____

YES NO Do you suffer from any cardiac problems? Please explain: _____

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

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?

Please list medications currently being taken: _____

Please list previous surgeries and dates: _____

CONTRAST HISTORY: These particular items MAY not allow us to proceed with the examination

YES NO Are you allergic to IODINE?

YES NO Have you previously been injected with x-ray dye for exams, such as Angiograms, CT or IVP?
 If YES, please indicate any problems after receiving contrast _____

YES NO Do you have Diabetes? If yes, are you taking any of the following?

Glucophage Glyuride Glucovane Metformin Other: _____

Date and time of last dose: _____

YES NO Do you have a history of kidney disease?

If YES, are you on dialysis: _____ Next scheduled dialysis: _____

YES NO 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: _____

YES NO Do you have a history of pheocromocytoma (adrenal gland tumor)?

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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 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 unborn fetus in the event I am pregnant.

Patient Initials: _____

AFFILIATED RADIOLOGISTS' AUTHORIZATION

I hereby authorize Midwest Orthopaedics, its physicians, nurses, employees or agents to furnish to any representative, agent or employee, nurse or physician of Affiliated Radiologists, S.C. any and all records, reports and information including but not limited to any and all medical records, diagnostic imaging studies, consultation reports, discharge summaries, histories and physical examinations, operative reports, laboratory reports, x-ray reports, nurses' notes, demographic information and any billing or insurance information needed to interpret my diagnostic imaging studies; to determine any and all diagnosis, treatment or prognosis; and to facilitate the billing by Affiliated Radiologist for its professional services.

Upon presentation of this authorization or an exact photocopy thereof, which shall be considered as valid as the original, Midwest Orthopaedics is directed to permit the personal review, copying or photocopying of all such records, reports, information and diagnostic imaging studies by a representative of Affiliated Radiologists, S.C. This authorization expressly waives any requirements that it must be used within a certain amount of days or within any period after the date hereof. I reserve the right to revoke this authorization at any time, but this will not apply to information already released.

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:** _____

Technologist Signature: _____ **Date:** _____

Printed RT Name: _____