

CT AND IV CONTRAST HISTORY AND SCREENING FORM

Today's Date: _____ Referring Physician: _____

Patient Name _____ Sex: M F
DOB: _____ Age: _____ Weight: _____ Height: _____

Explain your medical problem in detail that is the reason for you having this CAT Scan test today.
(Where is the problem? How long have you had this problem?)

Have you had a previous exam related to this problem? Yes No If yes, where was the exam performed? _____

List other medical problems: _____

List previous surgeries: _____

List all allergies: _____

CONTRAST HISTORY

Are you taking Glucophage or Metformin? Yes No BUN _____ CREATINE _____

Have you ever had an allergic reaction to x-ray contrast? Yes No
If yes, explain: _____

Any personal history of:

Asthma	Yes	No
Diabetes	Yes	No
Kidney Disease	Yes	No
Cancer	Yes	No
Multiple Myeloma	Yes	No
Are you breast-feeding?	Yes	No
Are you pregnant at this time?	Yes	No
Are you on any blood thinners?	Yes	No
When was the first day of your last menstrual cycle?	_____	
What birth-control method are you currently using?	_____	

I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist **that I am not pregnant** at this time.

PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE TECHNOLOGIST/WITNESS SIGNATURE DATE

For Technologist to Complete

Not applicable to this exam			
_____ CC With a	_____ @	_____ X	
Amount	GA & Needle Type	Time	# of punctures
In	Lot	Expiration Date:	
Site Location	By:	_____	
Contrast Reaction	Yes	No	Physician Covering Contrast
Explain	_____		

ENVISION IMAGING
INFORMED CONSENT FOR CAT SCAN WITH OR WITHOUT
CONTRAST INJECTION

PATIENT NAME: _____

IF YOU ARE PREGNANT OR THINK THAT YOU MAY BE PREGNANT, PLEASE INFORM THE FACILITY PERSONNEL AT ONCE.

Your physician has requested that we perform a computerized tomography scan (CT) to obtain additional information. This is a diagnostic test that uses x-ray and a computer to produce images of internal body parts.

As part of your examination, we may need to inject you with a contrast solution containing iodine. This clear, colorless liquid is removed from your body by your kidneys and will not alter the appearance of your urine. It will show up on the images to provide important diagnostic information.

Soon after the injection you may experience a metallic taste and a warm sensation. You may feel some nausea. These feelings last only a short time.

Occasionally, minor allergic reactions occur in the form of itching, sneezing, hives, swelling of the eyes or wheezing. These symptoms may require treatment with medication we have on hand. It is very important that you inform the technologist if you experience any of the conditions mentioned in this form.

Rarely, a more serious reaction will occur. Even though it is extremely rare, medical statistics indicate that a fatality may occur from the injection of contrast. If you have had a reaction to a contrast injection previously or a history of asthma or other allergic conditions, any history of diabetes or any kidney disorder, anemia or sickle cell anemia, if you are taking Glucophage, are pregnant or breast feeding, you **MUST** inform the technologist.

The benefit of this exam is to assist your physician with making a diagnosis. There may be other imaging alternatives, however, your physician believes the CAT scan to be the best diagnostic test for you after evaluating your symptoms and medical condition.

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to me. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

DATE: _____ TIME: _____

Patient/Parent/Legal Guardian Signature

DATE: _____ TIME: _____

Witness Signature



PHONE: 817-741-0008
FAX: 817-741-3908

**PATIENT AUTHORIZATION
FOR THE RELEASE OF PROTECTED HEALTH INFORMATION
TO A CENTER**

PATIENT NAME: _____
DATE OF BIRTH: _____
ADDRESS: _____
PHONE: _____

In some cases, we need to review information contained in the medical records created for and about you by other physicians or healthcare facilities. In this setting it is normally to review images and reports acquired at a different imaging facility to help with your diagnosis.

By completing this form, you will authorize us to have access to such information.

Please list the Person/Facility that may release your medical information.



Information may be released to:

Information that may be released includes: *(please check one)*

- All information
- Only the following types of information. *(please specify)*

I authorize the release of the information specified to the above listed Center. I agree to pay reasonable charges for copies. I release all parties from any legal responsibility or liability for disclosures made pursuant to this authorization.

Patient Signature _____ Date: _____