CT Screening

Patient Name:____

Today's Date: ____________ **Age:** ______ **Weight:** ______ **Height:** ______ **Sex:** ☐ **M** ☐ **F**

	Yes	No	
	☐	☐	If female: is there any possibility you could be pregnant?
	☐	☐	Are you currently breastfeeding?
	☐	☐	Have you had a previous reaction to iodinated contrast media (i.e. CT contrast dye or X-ray dye)? If yes, describe reaction: ________________
	☐	☐	If you had a prior reaction to iodinated contrast media, have you been pre-medicated with a corticosteroid (such as Prednisone or Solu-Medrol)? ____________
	☐	☐	Do you have any allergies to food or medication? If yes, please list: ____________
	☐	☐	Do you have asthma?
	☐	☐	If yes, is your asthma currently affecting you?
Δ	☐	☐	Do you take Glucophage (Metformin)?
Δ	☐	☐	Do you have kidney disease or kidney failure or kidney transplant?
Δ	☐	☐	Do you have a history of kidney cancer or mass?
Δ	☐	☐	Do you have a family history of kidney failure?
Δ	☐	☐	Have you previously had kidney surgery?
*	☐	☐	Have you had a recent illness or infection in the past week? Type: ____________
*	☐	☐	Have you been feeling sick with nausea, vomiting or diarrhea?

Patient (or legal guardian) signature:	**Date:**	**Time:**
Patient Name (printed):	**Legal guardian printed name (if applicable):**	

THIS SECTION IS FOR STAFF USE ONLY

* Serum creatinine within 24 hours   Δ **Serum creatinine within 2 weeks if "Yes" to answer**

VASCULAR ACCESS:

DATE ____________ **TIME** ____________

TECHNOLOGIST / RN ____________

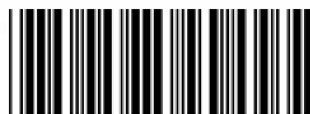
IV SITE ____________ ☐ **18g** ☐ **20g** ☐ **22g** **ATTEMPTS** ______

☐ **OTHER** ____________

CREAT / GFR ____________

NOTES ____________

PLACE PATIENT LABEL HERE



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