CT - COMPUTERIZED AXIAL TOMOGRAPHY

☐ **Cascade Medical Imaging, LLC - Eastside**
☐ **Cascade Medical Imaging LLC - SCMC Bend**
☐ **Cascade Medical Imaging LLC - SCMC Redmond**

Today's Date: ____/____/_______ Name: ______________________________

Date of Birth: ____/____/_______ Age: _____ ☐Male ☐Female Referring Dr: ______________________________

Briefly describe the problem(s) you are experiencing that made you see your doctor: ______________________________

____

____

Have you ever had any surgery in the area you are currently having problems? ☐ Yes ☐ No

Type of Surgery: ______________________________

Do you have a personal history of cancer in any part of your body? ☐ Yes ☐ No

What **part** of your body and **when** was the diagnosis made? ______________________________

____

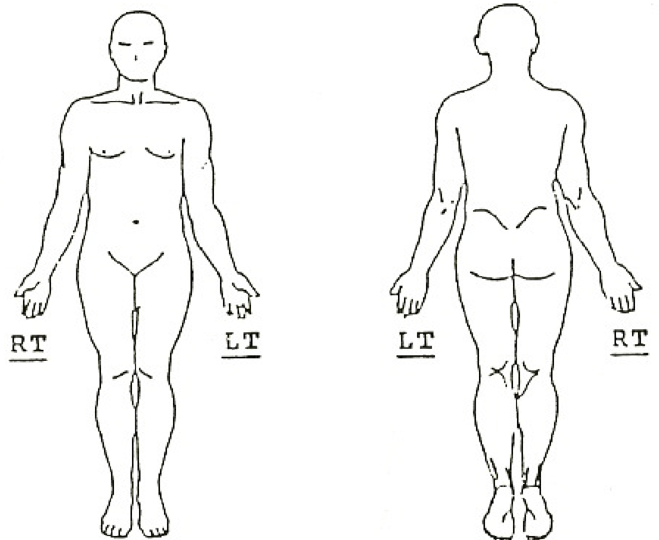
PLEASE INDICATE BELOW ANY PREVIOUS PERTINENT STUDIES YOU HAVE HAD, WHEN THEY WERE PERFORMED AND AT WHAT FACILITY:

X-Rays: ______________________ MRI: ______________________

CT Scan: ______________________ Nuclear Medicine: ______________________

Ultrasound: ______________________ Other: ______________________

Please use this diagram to mark where you think your problem is located or where you are feeling pain → →



FOR OFFICE USE ONLY

Technologist:_______________ **Contrast Amount Given**:________________________ **IV Location**:________________________

Notes:____

PLACE MEDI-TAPE STICKER HERE

ct scan #16 all locations pronto 8-13-08 cdd

CONSENT FOR CONTRAST MATERIAL INJECTION

CT uses a thin beam of low dose diagnostic x-ray with advanced computer technology to create a series of images that the radiologist reviews. Your physician has chosen contrast CT because it provides an ability to see certain kinds of pathology.

The contrast material is a clear liquid given through a small needle and injected into a vein in your arm. Normally, contrast material is considered quite safe. However, any injection carries a slight risk of harm including injury to a nerve, artery, vein, and infection or allergic reaction. Occasionally the patient will develop sneezing or hives. Uncommonly, (one case in a 1000) a serious reaction to contrast occurs. Very rarely, (one case in 40,000) death has occurred related to the contrast administration. The risk of such a severe consequence is similar to that from the administration of penicillin. Our radiologists and staff are trained to treat these reactions.

Certain patients are at higher risk for experiencing a reaction to the contrast agent. We would like to identify these patients in order to take appropriate measures to try to prevent a reaction. Please fill out the check list below to help us prepare for your CT scan:

YES	NO	Do you have **ANY** of the following conditions:
☐	☐	Are you on dialysis or do you have a history of kidney failure?
☐	☐	Have you had a kidney removed?
☐	☐	Are you diabetic? (250.00 insulin dependent)
☐	☐	Do you have a history of cancer or any chronic illness?
☐	☐	Do you have a history of heart disease? (V12.50 hx of)
☐	☐	Are you older than 70?
☐	☐	Do you have a history of long-standing or poorly controlled hypertension? (401.9)

If you are at high risk we may prescribe medicine to be taken during the twelve hours before the injection to try to "block" an adverse reaction. We also use the newer family of contrast agents called "low osmolor" or "non-ionic". X-ray contrast has a long record of safety and effectiveness and these newer agents appear to have a lower incidence of reactions. However, serious reactions can still occur with low osmolar or non-ionic agents. If you have any questions, you are encouraged and expected to ask your CT radiographer or the radiologist.

YES	NO	Do you have **ANY** of the following apply to you:
☐	☐	Do you take Glucophage (Metformin) or Glucovance? (V58.69)
☐	☐	Do you have asthma? (493.90)
☐	☐	Do you have a known allergy to x-ray contrast? (V15.08)

Your signature on this form indicates that:

1. You read and understood the information provided in this form.
2. You have had a chance to ask questions.
3. You have received all information you desire concerning the procedure, and
4. You authorize and consent to the performance of the procedure.

____________________________ Patient Signature

____________________________ Print Patient Name

____________________________ Witness

____________________________ Date