CO0010

SOUTHAMPTON HOSPITAL

240 MEETING HOUSE LANE, SOUTHAMPTON, N.Y. 11968

Imaging Department

Patient CAT Scan Questionnaire

NAME:	Date of Birth:	MR#
Your Doctor's Name:	Today's Date	

1. REASON FOR CAT SCAN? _____

_____

WHAT ARE YOUR SYMPTOMS? _____

HOW LONG HAVE YOU HAD THEM? _____

2. PAIN LEVEL _____ **SCALE:** _____

Please Answer these Questions (circle Yes or No)

1. Have you had a prior ALLERGIC reaction to contrast dye?	Yes	No
2. Do you have Multiple Myeloma/Sickle Cell Anemia?	Yes	No
3. Do you have Asthma?	Yes	No
4. Do you have heart disease?	Yes	No
5. Do you have kidney disease or on Hemodialysis?	Yes	No
6. Do you have any history of cancer?	Yes	No
7. Do you have diabetes? If yes, how long:	Yes	No
8. Are you taking Metformin, Glucophage, Glucovance, Metaglip, Avandamet, Fortamet, Riomet, Actoplus Met, Interlukin, Glumetza, Janumet, Prandimet, or Kombiglyzexr? (circle)	Yes	No
9. Have you had a mastectomy or Lymph node dissection? Which side?	Yes	No
10. *FEMALES ONLY:*		
Is there any chance of pregnancy? or are you breastfeeding?	Yes	No

ALLERGIES: _____

PRESENT MEDICATIONS: _____

_____ Reviewed by: _____

MEDICAL HISTORY: _____

_____

PREVIOUS SURGICAL HISTORY: _____

_____

Upon leaving the facility please give the list of your current meds to your health care provider/physician. Keep your medication list current and up to date. You can do this by revising your list when medications are discontinued, the dose is changed, or new medications (including over the counter medications) are added. Carry the list with you at all times should an emergency situation arise.

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FOR RADIOLOGICAL STAFF-TO COMPLETE. (TECHNOLOGISTS AND NURSES)

Any prior CT scans (when/where?): _____

Laboratory Data: Creatinine: _____ eGFR: _____ Date: _____ Drawn at: _____

Pt. Assessment: Alert: YES or NO Procedure Explained: YES or NO Verbalizes Understanding: YES or NO

Oral Contrast: Positive/Negative Type: _____ Amount: _____ ml started drinking at: _____

IV Contrast: Type: _____ , Volume: _____ ml

Intravenous Site: # _____ g in _____ Circle one: In Place or Started By: (Initials)

Injection: Hand or Power injection @ _____ ml/second flow rate.

Post Contrast: ❑ Patient tolerated injection well.

Advised to drink several glasses of water today: YES or NO Diabetic instructions given: YES or N/A

Additional Notes or changes: _____ Date: _____

Injection by: _____ Scan completed by: _____, RT Time: _____

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Authorization for Intravenous Contrast Media

Patient Name: _____

DOB: _____

Your physician has requested an Intravenous Computerized Tomography of _____ to be performed. This test uses specialized imaging techniques to view particular anatomy within your body. Your doctor has ordered this procedure with the expectation that it will provide necessary information to better understand and treat your medical problem.

As part of this exam you will be given an iodine based non-ionic contrast media through a small catheter which is placed into a vein. This contrast media is injected while imaging is performed. Normally, you may experience a warm, flushed feeling, a metallic taste in the mouth, and rarely, a mild wave of nausea. However, there may be an allergic-type reaction to the contrast. Most reactions occur within 20 minutes of the injection. The physicians and staff of the Radiology Department are trained to treat these reactions if they occur.

MINOR REACTIONS: itching, hives, sneezing–may or may not require treatment.
SERIOUS REACTIONS: shortness of breath, irregular heartbeat, difficulty swallowing, facial swelling, abnormal blood pressure, unconsciousness, renal failure, heart attack and/or cardiac arrest.
FATAL REACTIONS: Rarely, as with many drugs, contrast media can cause death. The chance is extremely rare.

Certain patients are at a higher risk for adverse effects, including those with a history of multiple allergies and asthma.
Certain patients are at a higher risk of kidney failure: (diabetes, heart failure, kidney failure). If you are medically able to, drinking plenty of fluids for 8 hours after the test will help minimize the effects.

If you have questions please ask Radiology nurse or Technologist. There is a Radiologist available to speak with you upon your request.

Women age 12-55: I believe that I am not pregnant, nor am I a nursing mother. _____ (Pt. initial)

I have read and understand the above and all of my questions have been answered.

YES☐NO☐

_____ (Patient Signature)	_____ (Date)	_____ (Time)
_____ (Parent/Legal Guardian)	_____ (Date)	_____ (Time)
_____ (Witness)	_____ (Date)	_____ (Time)
_____ (Physician)	_____ (Date)	_____ (Time)