Cambridge Health Alliance

Department of Radiology

IV Contrast Screening Form

Name:_____ Date of Birth: _____

MRN: _____ Exam Date: _____

Reason for your CT scan today _____

___Y ___N Have you had any previous study with injection of contrast media?

___Y ___N Previous reaction to contrast media
If yes, describe reaction _____

___Y ___N Do you have allergies to other medications or food?
If yes, please list: _____

___Y ___N Are you breast feeding?

___Y ___N Are you on dialysis? How often? _____

___Y ___N Do you have diabetes?

___Y ___N Are you taking Metformin, Metaglip, Glucophage, Glucovance for diabetes?

___Y ___N Are you pregnant?

Please check the boxes if you have any of the following:

- ☐ Diabetes
- ☐ Asthma
- ☐ Hypertension
- ☐ Heart disease
- ☐ Arrhythmias- irregular heart beats
- ☐ Kidney disease
- ☐ Lung disease
- ☐ Respiratory failure
- ☐ Sickle cell disease
- ☐ Multiple myeloma
- ☐ Thyroid disease
- ☐ History of transplant/ type
- ☐ Cancer / history of cancer
- ☐ Pheochromocytoma
- ☐ Type of cancer _____
  - Radiation therapy
  - Chemotherapy

Existing IV? **Y N**	If yes, disregard boxes	Complete all questions
IV Starts / Restarts		Patient tolerated procedure well? ___ Y ___N
Time		Aftercare instructions given and understood? ___ Y ___N
IV Site		Contrast: _____ ml: _____
Type/Size		Reaction: _____ ___ Y ___N
Tech/RN:		

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