



CT SCREENING/CONTRAST CONSENT FORM

Name: _____ DOB: _____ Height: _____ Weight: _____

Date: _____ Referring Doctor: _____ Radiology #: _____

PATIENT PLEASE ANSWER THE FOLLOWING QUESTIONS:

1) What complaints/symptoms led you to see the doctor?

Duration of Symptoms _____

2) **Allergies _____

Latex sensitivity/allergy Yes No

3) Allergy to Iodine Yes No

4) **Previous injection of X-Ray Dye for exams such as
Angiogram, CT, IVP Yes No
a) Any Problems after receiving dye? _____

5) **Diabetes Yes No

Diabetic medication _____
How long have you been on medication? _____

6) **Kidney Disease Yes No

a) Dialysis Yes No
Next Dialysis _____

b) Pheochromocytoma Yes No

7) Cardiac Problems Yes No

8) Stroke Yes No

9) **Personal Cancer History Yes No

a) Type and date diagnosed _____

b) Chemo Yes No
Date of last treatment _____

c) Radiation Yes No
Date of last treatment _____

10) Multiple Myeloma Yes No

11) Weight loss Yes No

Amount _____ lbs. Time Frame _____

12) Respiratory Problems Yes No

a) Please circle: Asthma Emphysema
Bronchitis

b) History of smoking Yes No

13) Alcohol Consumption Yes No

14) Medications: _____

15) High Blood Pressure Yes No

16) Please list ALL previous surgeries and dates

17) Please list all tests done in past 6 months and where they were done

TEST	FACILITY
_____	_____
_____	_____
_____	_____
_____	_____

These particular items may not allow us to proceed with your examination

Patient Signature _____

BELOW LINE IS FOR TECHNOLOGIST'S USE ONLY!!

TECHNOLOGIST'S NOTES ONLY

Staff Signature _____



Patient Name (PRINT) _____

I understand contrast material will be injected. The indications for and risks of the procedure known as a CT SCAN were discussed with me. The risks were noted to include, but are not limited to, various types of allergic reactions to the intravenous contrast (such as iodinated contrast etc.). Most of these reactions are minor, although they can be severe at times. On rare occasions, inflammation or infection at the site can occur and other more remote risks or consequences may also arise.

I have been advised that if further explanation is desired, I may ask additional questions to the staff to include any supervising radiologists and my referring physician.

Signature of patient or legal guardian

Date

Staff witness to signature

Date

FEMALE PATIENTS:

I AM PREGNANT

I AM NOT PREGNANT / LMP _____

I understand I will be receiving x-rays and hereby release all radiologists, respective staff and the facility thereof of any and all responsibility for any adverse reaction to myself and/or damage to my unborn fetus in the event I may be pregnant.

SIGNATURE _____