Baylor Scott & White
SURGICAL HOSPITAL AT SHERMAN
Joint ownership with physicians

Patient Label

CT PATIENT INFORMATION SHEET

Patient must answer all questions Yes/No or N/A
Form must be signed and dated by patient and technologist

_____1. Have you had IV or Oral contrast (iodine, dye) before?

_____2. If yes, did you have an allergic reaction? Describe:_____

_____3. If you have experienced an allergic reaction to IV or Oral (iodine, dye) contrast, did your doctor pre-medicate you to prevent an allergic reaction?

_____4. Are you diabetic? If yes, what medication are you taking?_____
(Refrain from taking any form of Glucophage/Metformin for 48 hours)

_____5. Are you currently breastfeeding? If yes, the patient must be educated in accordance with ACR recommendations. Patients may want to refrain from breastfeeding for 24 hours after the administration of IV contrast.

6. List any food and/or drug allergies: _____
_____

7. Any history of the following: Please circle

Abd pain	Kidney Disease	Chest Pain/MI	
Pelvic pain	SOB	Nausea/Vomiting	
High BP	Emphysema	Recent Trauma	
Wt Loss	Lung Disease	GI Disease	
Stroke	Asthma	Heart Disease	
Headache	Sickle Cell Disease	Multiple Myeloma	Cancer

8. Reason for study:_____

9. List all surgeries_____

Patient Signature: _____ Date/Time: _____
If administration of IV contrast is contraindicated, administration of IV contrast can only be made upon physician authorization.

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TECHNOLOGIST TO COMPLETE

Correct Patient ____ Correct Imaging Site _____
Prior Exams _____
Patient Creatinine_____ Patient Weight_____ Inj. Site_____
Contrast Name_____ Dose_____ Lot#_____ Exp_____

Technologist: _____ Date/Time: _____