CT DOCUMENTATION

PATIENT NAME:_____ **DOB:**_____ **MR#:**_____

Weight:_____ **Height:**_____ **DOS:**_____ **EXAM:**_____

PREFERRED LANGUAGE:_____ **Age:**_____ **(60 and over need labs)**

Any special needs? O2 (Oxygen), a Wheelchair etc_____

YES	NO	PATIENT HISTORY
☐	☐	**Diabetic** _____
☐	☐	History of Heart Disease (angina, high BP, heart attack, CHF, Heart murmur) _____
☐	☐	Kidney Disease, HX of Kidney Stones _____
☐	☐	Liver Disease (hepatitis) Seizures _____
☐	☐	History of Lung Disease (COPD, asthma, emphysema, tuberculosis, bronchitis)_____
☐	☐	Multiple Myeloma, Sickle Cell Disease, Cancer _____
☐	☐	Other: _____

Symptoms today: _____

_____

Has there ever been a problem with medical staff starting IV's or drawing blood?_____

ALLERGIES ☐ **None** **PREVIOUS CT CONTRAST SENSITIVITY/IODINE? ☐ YES ☐ NO (if yes see back)**

LIST ALLERGIES / INTOLERANCES	REACTION CODES*	SEVERITY CODES*

***REACTION CODES:** 1=Anaphylactic 2=Breathing problems 3=Ear, Nose and Throat swelling 4=Mental changes 5=GI disturbances 6=Skin reactions 7=Cardiac 8=Renal disturbances 9=Neurological Changes: ***SEVERITY CODES:** M=Mild MO=Moderate S=Severe: ***TREAT AS LATEX ALLERGY:** Type 1 unknown allergy, or anyone with neural tube defect or food allergies to avocado, banana, or chestnuts

SURGERY HISTORY (please include date and hospital name)	CURRENT MEDICATIONS

Metformin ☐ YES ☐ NO

Have you ever had an IMAGING study of the SAME BODY PART we are examining today? NO_____ YES_____

IF YES PLEASE LIST: **Date** **Facility**

MRI _____

CT _____

US _____

XRAY _____

OTHER _____

PATIENT NAME:_____ DOB:_____ MR#:_____

IV	FOR TECHNOLOGIST USE ONLY
Needle Gage: 18 19 20 21 22 24	Location: ☐ Right ☐ Left
Number of sticks: _____ Time: _____	☐ Antecubital ☐ Forearm ☐ Hand
	Other: _____
Oral Contrast: ☐ Gastro ☐ Mannitol ☐ Volumen ☐ None	
Contrast Given: ☐ YES ☐ NO Lot#_____ Expir. Date: _____ Amount: _____	

_____ _____

Patient Signature Technologist Signature

Labs:

CONTRAST REACTION PROTOCOL
FOR PRIOR CONTRAST REACTION:

CORTICOSTEROID:
METHYLPRENISOLONE 32MG (this is a prescription)

- 12 HOURS PRIOR
- 2 HOURS PRIOR

ANTTIHISTAMINE:
BENADRYL 50MG

- 1 HOUR PRIOR