Denver Integrated Imaging

COMPUTED TOMOGRAPHY (CT) PROCEDURE SCREENING FORM FOR PATIENTS

Date _____/_____/_____

Name _____ Age _____ Height _____ Weight _____
Last name First name

Date of Birth _____/_____/_____ Male Female Body Part to be Examined_____

Reason for CT and/or Symptoms:

_____

How long have you been treated for this injury/illness: _____

Referring Physician _____ Telephone (_____) _____-_____

1. Have you had prior surgery or an operation of any kind? No Yes
If yes, please indicate the date and type of surgery:
Date _____/_____/_____ Type of surgery _____

Date _____/_____/_____ Type of surgery _____

2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? No Yes
If yes, please list:

	Body part	Date	Facility
MRI	_____	_____/_____/_____	_____
CT/CAT Scan	_____	_____/_____/_____	_____
X-Ray	_____	_____/_____/_____	_____
Ultrasound	_____	_____/_____/_____	_____
Nuclear Medicine	_____	_____/_____/_____	_____
Other	_____	_____/_____/_____	_____

3. Have you ever had cancer Yes No
If yes, please indicate the type _____
Did you have radiation therapy? Yes No
Did you have chemotherapy? Yes No

4. Do you have any other medical problems? Yes No
If yes, please explain: _____

5. Do you have any allergies? Yes No
If yes, please list: _____

6. Do you have any food allergies? Yes No
If yes, please list: _____

Yes No Are you diabetic?
Yes No Do you take Glucophage or Metaphormin Hydrochloride?
Yes No Do you have Asthma?
Yes No Do you have Sickle Cell Disease or Sickle Cell Trait?
Yes No Do you have Kidney or Liver Disease?

(Next page)

For female patients:

1. Date of last menstrual period: _____/_____/_____ Post menopausal? No Yes
2. Are you pregnant or experiencing a late menstrual period? No Yes
3. Are you taking oral contraceptives or receiving hormonal treatment? No Yes
4. Are you taking any type of fertility medication or having fertility treatments? No Yes
5. Are you currently breastfeeding? No Yes

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and regarding the CT procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date _____/_____/_____

Form Completed By: _____ _____
Print name Relationship to patient

Please read and sign if you are also to have a CT with contrast.

Consent for Intravenous Contrast Agent

Your doctor has ordered your CT to be performed with an injectable contrast agent, to be administered to you intravenously (in the vein). It is nearly completely eliminated in the urine with 24 hours after injection. Its primary use is to provide contrast enhancement and make it easier to see areas of concern or interest, such as blood vessels or scar tissue.

I consent to the intravenous injection of contrasting agent. I understand that as with any medication, including these compounds, there is a risk of physical reactions. These have been explained to me and I consent to having this procedure.

Signature of Person Completing Form: _____ Date _____/_____/_____