Patient Name: _____ Today's Date _____

Patient Age: _____ Weight: _____

For Oral and IV Iodinated Contrast:

Do you have allergies to iodine? ☐ Yes ☐ No ☐ Not Applicable for this Exam

Do you have allergies to barium? ☐ Yes ☐ No ☐ Not Applicable for this Exam

Have you ever received X-Ray dye or CT Contrast before? ☐ Yes ☐ No When?_____

Have you ever had a contrast reaction before during a previous exam? ☐ Yes ☐ No

When? _____ What symptoms did you experience? _____

Do you have asthma? ☐ Yes ☐ No

For IV Iodinated Contrast Only:

Are you taking medicine to control blood pressure? ☐ Yes ☐ No

Do you have a history of cancer? ☐ Yes ☐ No If yes, what type of cancer? _____

Do you have a history of kidney disease? ☐ Yes ☐ No

Kidney transplant ☐ Yes ☐ No
Single kidney ☐ Yes ☐ No
Kidney surgery ☐ Yes ☐ No
Renal cancer ☐ Yes ☐ No
Currently on dialysis or previously had dialysis in the past? ☐ Yes ☐ No

Do you have diabetes? ☐ Yes ☐ No

Are you taking?

☐ Metformin ☐ Glucophage ☐ Fortamet ☐ Glumetza ☐ Riomet ☐ Glucovance ☐ Metaglip ☐ Actoplus Met

☐ PrandiMet ☐ Avandamet ☐ Kombiglyze ☐ Janumet

*If patient answers yes to any of these questions, document the Creatinine/GFR Values and inform the radiologist. Abnormal labs are a GFR of 49 or less. *For Pediatric patients with a GFR of 90 or below a radiologist must be consulted prior to administering contrast.

Signature of patient or guardian: _____

RN/Technologist Signature: _____ Date: _____ Time:_____

To be Completed by Technologist

Date of Lab Value: _____ Creatinine: _____ GFR: _____

Contrast Type: _____ Volume: _____ Injected by: _____

If proceeding with contrast administration despite abnormal lab values, please note reviewing physician:

_____

Health ONE North Suburban Medical Center
Health ONE North Suburban Medical Center Northeast ER
Health ONE North Suburban Medical Center Northwest ER

Contrast/Medication Patient Profile

Patient Information/Label

RADS
50101 (03/15)

Current Medication List

Inpatient or ED patient - see CLINICAL PATIENT CARE SYSTEM

North Suburban Medical Center is committed to your safety. We require a list of all current medications you are taking prior to administering any medications or contrast for your exam. Please complete the list below or attach a complete list of medications including medication name, dose, frequency, route, time last taken and physician who prescribes this medicine and sign at the bottom.

☐ **I do not take any medications at this time (*sign at bottom)**

Please include all over the counter meds, prescriptions, herbal supplements, vitamins, diet supplements, etc.

Medication Name	Dose (Ex.-3mg)	Frequency (How often)	Route (by mouth, patch, etc.)	Time Last Taken	Prescribing Physician

☐ I have taken medication(s) for contrast allergies prior to my exam today.

*Patient Signature: _____ Date: _____ Time: _____

☐ Reviewed by staff. Proceed with exam if no contraindications present. Follow protocol.

☐ Any contraindication, allergy risk or variation from protocol, notify physician.

Other contraindication: _____

Provider Signature: _____ Date: _____ Time:_____

Print Provider Name: _____

Technologist/RN Signature: _____ Date: _____ Time:_____

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Health ONE North Suburban Medical Center *Northwest ER*

Patient Information/Label

Contrast/Medication Patient Profile

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