

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: _____

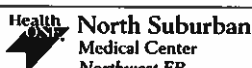
RN/Technologist Signature: _____ Date: _____ Time: _____

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:



Patient Information/Label



**Contrast/Medication
Patient Profile**

