Elevation Medical
IMAGING

CT History Form

Patient Name: _____ DOB: _____

Age: _____ Weight: _____

- Reason for exam today? _____
- Have you had a previous exam related to this problem? YES NO
- If yes, what type of exam?

  _____

  Where was the exam performed? _____ Date of Exam: _____
- **Females Only:** Are you Pregnant and/or Breastfeeding? YES NO

HEAD/FACE/SINUS:

Have you had any injuries to your head/face/sinus? YES NO

Have you had any head/face/sinus surgeries? YES NO

- If yes, what type of surgery? _____

CHEST: Select all that apply.

☐ Cough ☐ Shortness of Breath ☐ Fever ☐ History of Smoking

Chest Surgery: ☐ Stent ☐ Bypass ☐ Other: _____

ABDOMEN/PELVIS: Select all that apply.

☐ Pain ☐ Nausea ☐ Vomiting

☐ Diarrhea ☐ Constipation ☐ Blood in Urine ☐ Blood in Stool

Abd/Pel Surgery: ☐ Gallbladder ☐ Appendix ☐ Hernia Repair

☐ Tubal Ligation ☐ Hysterectomy (Total or Partial) ☐ Ovary (R or L or Both) ☐ Other: _____

Contrast Exams Only:

Are you allergic to iodine or CT IV Contrast? YES NO

- If yes, have you been pre-medicated for this exam? YES NO

Do you have any major drug allergies? YES NO

- List your allergies: _____

Do you have kidney disease or reduced renal function? YES NO

Are you diabetic or taking Metformin or Glucophage medications? YES NO

Do you have or have you ever had cancer? If yes, what Kind? _____ YES NO

Tech Initials: _____

Elevation Medical
IMAGING

CT IV Contrast Consent Form

As part of your CT examination, you will be given a prescribed amount of contrast material. Contrast is injected through an IV into a vein and is imaged with CT. Studies show that contrast material is considered safe, there are occasional side effects and reactions. Some of the reactions may include:

- **Minor reactions:** such as itchy hives or nausea.
- **Serious reactions:** shortness of breath, irregular heart rhythm, convulsions, kidney failure, or unconsciousness. These side effects may require immediate medical intervention.
- **Death:** this occurs rarely but is possible as with many drugs.

- Have you ever been given a CT contrast agent through an IV? YES NO
- Did you have a minor or serious reaction to the contrast? YES NO
    - If yes, did you have a minor or serious reaction? MINOR SERIOUS

By signing below, you are confirming that you have been **informed of the risks** and benefits of using IV contrast media for a radiological examination. You are authorizing Elevation Medical Imaging to administer the appropriate IV contrast required for your radiological examination and **you authorize any appropriate care or intervention** that may be required in conjunction with the specified CT IV contrast media **in the event of any adverse reactions**.

If you develop symptoms of an adverse reaction after leaving Elevation Medical Imaging, please seek care from your ordering physician or local emergency room.

_____ _____
Patient Signature (Unless Patient is minor or unable to sign) Date

_____ _____
Parent/Guardian/Legal Power of Attorney Date

For Staff Use Only:

Creatinine: _____ GFR: _____ Date: _____

IV Site/Gauge: _____ Rate: _____ Contrast Volume: _____ [Place contrast sticker here]

IV DC'D with Catheter Intact: YES NO

Complications: _____

Oral Contrast: YES NO Type of Oral Contrast: _____

On-Site Physician: _____

Consenting & Administering Technologist(s): _____ Date/Time: _____