Minidoka Memorial Hospital

CT CONTRAST RISK ASSESSMENT AND CONSENT FORM

Name _____Age_____ Height _____ Weight _____
Last Name First Name Middle Initial

Date of Birth _____/_____/_____ ▫ Male ▫ Female

Have you ever had a history of:

- ▫ Yes ▫ No Allergies _____
- ▫ Yes ▫ No Kidney disease (Dialysis, Kidney transplant, single kidney, renal cancer, or renal surgery)?

If yes please describe _____

- ▫ Yes ▫ No An Adverse Reaction to Contrast Media or Medication?

If yes please describe _____

- ▫ Yes ▫ No Cardiac Disease (CHF, or COPD)
- ▫ Yes ▫ No Multiple Myeloma
- ▫ Yes ▫ No Insulin-Dependent Diabetes
- ▫ Yes ▫ No Do you take Glucophage, Metformin, Glucovance, Avandamet, Metaglip, Riomet, or Fortamet?
- ▫ Yes ▫ No Asthma
- ▫ Yes ▫ No Sickle Cell Anemia
- ▫ Yes ▫ No Any chance you are pregnant?
- ▫ Yes ▫ No Currently breastfeeding?

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

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

Form Completed By: ▫ Patient ▫ Relative ▫ Nurse _____ _____
Print Name Relationship to Patient

********** **TECHNOLOGIST USE ONLY** **********

CREATININE:_____ GFR:_____ Location & Date Drawn (must be in the last 30 days):_____

_____cc's of Omnipaque/Visipaque _____ with a _____@_____ Wasted Contrast _____cc's
GA & Type *Time*

X_____In _____ Contrast Lot #_____ Exp. Date: _____
# of Punctures *Site Location*

Contrast Reaction: Yes/No Explain:_____

_____ _____
Technologist Signature Date