Methodist Le Bonheur Healthcare

Place Patient Label Here

Patient Assessment for Vascular Contrast Studies

1. Reason(s) for today's exam ____
   ____
2. Is there any chance you may be pregnant? .... Yes No
3. Are you breastfeeding? .... Yes No
4. Have you ever had IV contrast for any of the following procedures? .... Yes No
   (e.g. CT Scan, IVP, Angiogram, Cardiac Catheterization)
5. Have you ever had an allergic reaction to IV contrast? .... Yes No
   If yes, what reaction did you have? ______________________________
6. Do you have a personal history of cancer? .... Yes No
   If so, what type(s)? ______________________________
7. Do you have a history of surgery in the area being scanned? If so, what and when? ______________
   ____
8. Do you have a history of the following conditions?
   - Liver Disease .... Yes No
   - Thyroid Disease .... Yes No
   - Heart Disease .... Yes No
   - Asthma/Other Lung Disease .... Yes No

If Patient is age 60 and over, or answers "Yes" to any of the following conditions, eGFR will be needed.

- Kidney Disease/Kidney Failure/Surgery .... Yes No
  - If yes, explain: ______________________________
- Diabetes .... Yes No
  - If yes, what medication(s): ______________________________
- High Blood Pressure/Hypertension requiring medication .... Yes No
- Paraproteinemia Disease (e.g. Multiple Myeloma) .... Yes No
- Collagen Vascular Disease (e.g. Scleroderma, Lupus) .... Yes No
- Sickle Cell .... Yes No

Patient Signature (Parent or Guardian)______________________ Date ______________

Reviewing Associate's Signature ______________________ Date/Time ______________

DATE OF LAB RESULTS______________ GFR__________ BUN__________ CREATININE__________

Type of Device	Size	Site	Inserted by	# of Attempts	Date	Time

Contrast/Flush	Amt Given ML	Amt Wasted ML	Total ML
Saline pre-contrast			
Saline post-contrast			

IV/Device Removed? Yes No Removed by: ______________ Date/Time______________