Methodist Le Bonheur Healthcare

Place Patient Label Here

Patient Assessment for Vascular Contrast Studies

1. Reason/Symptoms 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(s) did you have? _____
   Are you pre-medicated for today's exam? ..... Yes No
   If so, what medications/doses? _____
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
   Dialysis ..... Yes No
9. Do you have an Insulin Pump?..... Yes No

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

Kidney Disease/Kidney Failure/Surgery ..... Yes No
If yes, explain: _____
Diabetes ..... Yes No
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 Signature _____ Date/Time _____

DATE OF LAB RESULTS_____ GFR_____ BUN_____ CREATININE_____

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

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

IV/Device Removed? Yes No Removed by: _____ Date/Time_____