CT Contrast Questionnaire

If you have any queries, please e-mail: fclradiographer@fortiusclinic.com

{Affix Patient Label Here}

Patient Name

Date of Birth Weight Height

Please bring this form and your request form/letter to your appointment.

Have you ever had a CT scan before?..... Date of last CT scan.....

Please answer the below questions carefully. If you answer YES to any of the following, please contact fclradiographer@fortiusclinic.com	Yes	No
Have you ever had contrast media or dye injection as part of a CT scan?		
Are you allergic to iodine and/ or anti-coagulant drugs?		
Do you have any other known allergies? *If so please list*		
Have you ever had an allergic reaction to a contrast media or dye injection?		
Have you ever had any heart surgery?		
Are you asthmatic?		
Are you taking any medication?		
Do you take Metformin/Glucophage?		
Are you currently taking beta blockers such as Metoprolol or Verapamil?.		
Could you be pregnant?		

Do you suffer from any of the following? Please read carefully and circle any that apply to you:

- High or low blood pressure
- Diabetes
- Kidney problems or renal surgery
- Respiratory disease
- Heart problems including surgery
- Hyperthyroidism
- Severe liver impairment
- Epilepsy
- Gout
- Glaucoma
- Myeloma
- Myasthenia gravis
- Interleukin 2
- Sickle cell disease
- Adrenal gland tumour

I confirm that I have been asked the above questions and the information is correct to the best of my knowledge. I consent to the examination and the intravenous injection needed. I confirm the risks and benefits of the contrast injection have been explained to me and I consent to the injection.

Signature of Patient Date

Signature of Radiographer Date

fortius clinic
Part of Affidea Group

FOR STAFF USE ONLY – CANNULA AND CONTRAST RECORDS

SITE OF CANNULATION **RT ACF** **LT ACF** **RT HAND** **LT HAND** **RT WRIST** **LT WRIST** OTHER……		
ROUTE: IV	**ATTEMPTS:**	**QUANTITY:**
INJECTED BY:	**INSERTED BY:**	

DRUG ADMINISTRATION RECORD							
Medicine name/ Form (BNF approved)	Dose	Route	Batch Number	Expiry Date	Administrator's Signature	Print Name	2nd Check Initials
		IV					

If you consider patient has increased risk of contrast reaction check with radiologist. Checked by Radiologist: Radiologist Outcome: 1: No contrast 2: Contrast given, Benefits>Risk Keep Patient for 30 MINS	
Creatine	EGFR

I confirm that I have checked the referral for the following:

Correct Patient Identified	
Correct Modality selected	
Areas to be scanned are compatible with clinical details	
Protocol is relevant to modality/areas to be scanned/clinical details	

Radiographer Signature _____ Date _____

Counter checked by Signature _____ Date _____