BLUE STAR IMAGING
Boerne

CT SCREENING FORM

Patient Name: _____

Date of Birth: _____

Male Female Weight: _____ Height: _____

ARE YOU DIABETIC OR HAVE RENAL DISEASE? ☐ YES ☐ NO
IF YES, ARE YOU CURRENTLY TAKING METFORMIN? ☐ YES ☐ NO
CLAUSTROPHOBIC: ☐ YES ☐ NO

What symptoms are you experiencing? _____

Referring Physician: _____

PLEASE CHECK BELOW ALL OF THE MEDICAL CONDITIONS THAT APPLY TO YOU:

☐ YES ☐ NO Have you ever had IV contrast (dye) injection in the past? (Cardiac Cath, CT, MRI, Other)
☐ YES ☐ NO Are you allergic to iodine or iodine containing substance? _____
☐ YES ☐ NO Do you have both kidneys? _____
☐ YES ☐ NO Do you have asthma or lung disease? _____
☐ YES ☐ NO Have you been diagnosed with epilepsy or seizure disorder? _____
☐ YES ☐ NO Do you have high blood pressure (hypertension)? _____
☐ YES ☐ NO Do you have heart disease? _____
☐ YES ☐ NO Do you have a history of cancer; if yes, explain: _____
☐ YES ☐ NO Do you have a history of stroke? _____

FEMALE PATIENTS

☐ YES ☐ NO Is there a chance that you are pregnant?
☐ YES ☐ NO Are you currently pregnant?
☐ YES ☐ NO Have you had a hysterectomy or tubal ligation?
☐ YES ☐ NO Are you currently nursing?

FORM OF BIRTH CONTROL

Abstinence
Birth Control Pill/Patch
Diaphragm
Vasectomy
Condom
IUD
Menopause
None

Patient Signature: _____ **Date:** _____

CONTRAST PATIENTS ONLY

Your physician has requested that we perform a diagnostic imaging exam to obtain additional information. As part of your exam, a contrast agent may be injected into your vein in order to produce better images of the indicated area. Potential risk include; pain, bleeding, bruising, swelling, mild headache, nausea, itching or other vague symptoms for a short time after the injection. Additional allergic reactions in response to the contrast agent may include: hives, shortness of breath, or difficulty swallowing. **It is very important that you inform the technologist if you experience any of the conditions mentioned on this form.**

NOTE TO PATIENTS: Please inform the technologist if any of the following apply to you: Previous reaction to contrast injection such as hives, severe itching, shortness of breath and/or any significant reaction requiring hospitalization, a history of asthma or other allergic conditions, any history of kidney disorders, Sickle Cell Anemia for MRI exams, and if you are pregnant or breast feeding. Please inform the technologist if you are taking a form of Metformin medication for CT exams.

_____ _____
Patient | Guardian Signature **Date:**

_____ _____
Technologist Signature **Date:**

INTERNAL USE ONLY:

CREATININE LEVEL: _____ GFR LEVEL: _____ml/min CONTRAST: _____ CC: _____

IV SITE: _____ IV: _____ # OF PUNCTURES _____ TECH: _____ GAUGE: _____ LOT #: _____ EXP: _____

CONTRAST COVERAGE BY: _____