

CONTRAST SCREENING & CONSENT FORM

DIAGNOSTIC IMAGING ASSOCIATES

100 College Parkway
Suite 180
Williamsville, NY 14221

PATIENT NAME: _____ DATE: _____
 DATE OF BIRTH: _____
 WEIGHT: _____ LAST MENSTRUAL PERIOD: _____

TEST ORDERED: CT MRI IVP ARTHROGRAM

PLEASE STATE REASON FOR TEST BEING ORDERED: _____

<p>ALLERGIES: <input type="checkbox"/> None <input type="checkbox"/> Unknown</p> <p>Have you ever had IV contrast? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, have you ever had an allergic reaction to the IV contrast? <input type="checkbox"/> YES <input type="checkbox"/> NO If YES, please give a brief description of the type of reaction you had: _____ _____</p>	<p>PAST MEDICAL HISTORY: <input type="checkbox"/> None</p> <table style="width: 100%;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Respiratory Distress <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Blood Disorder <input type="checkbox"/> Cancer <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Dialysis: <input type="checkbox"/> Peritoneal <input type="checkbox"/> Hemo <input type="checkbox"/> Thyroid Problems: <input type="checkbox"/> Hyper <input type="checkbox"/> Hypo <input type="checkbox"/> Asthma: Last Attack: _____ Treatment: _____ </td> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Airway Problems <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Adrenal Tumors (Pheochromocytoma) <input type="checkbox"/> Sickle Cell Disease/Trait <input type="checkbox"/> Multiple Myeloma <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Diabetes: <input type="checkbox"/> Oral Meds <input type="checkbox"/> Insulin Dependent <input type="checkbox"/> Blood Pressure Problems: <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> Heart Disease: _____ </td> </tr> </table>	<input type="checkbox"/> Respiratory Distress <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Blood Disorder <input type="checkbox"/> Cancer <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Dialysis: <input type="checkbox"/> Peritoneal <input type="checkbox"/> Hemo <input type="checkbox"/> Thyroid Problems: <input type="checkbox"/> Hyper <input type="checkbox"/> Hypo <input type="checkbox"/> Asthma: Last Attack: _____ Treatment: _____	<input type="checkbox"/> Airway Problems <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Adrenal Tumors (Pheochromocytoma) <input type="checkbox"/> Sickle Cell Disease/Trait <input type="checkbox"/> Multiple Myeloma <input type="checkbox"/> Chemotherapy <input type="checkbox"/> Diabetes: <input type="checkbox"/> Oral Meds <input type="checkbox"/> Insulin Dependent <input type="checkbox"/> Blood Pressure Problems: <input type="checkbox"/> High <input type="checkbox"/> Low <input type="checkbox"/> Heart Disease: _____													
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<p>CURRENT MEDICATIONS: (Prescription/OTC/Herbals) <input type="checkbox"/> None <input type="checkbox"/> Unknown</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Medications</th> <th style="text-align: left;">Dose</th> <th style="text-align: left;">Frequency</th> </tr> </thead> <tbody> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> <tr><td>_____</td><td>_____</td><td>_____</td></tr> </tbody> </table> <p>(CONTINUE MEDICATION LIST ON BACK IF NECESSARY)</p>	Medications	Dose	Frequency	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	
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I have answered the above questions to the best of my ability. I have been made aware of the risks relative to the injection of contrast. I consent to this exam and the injection of contrast.

 (Patient/Legal Guardian) DATE: _____

* * * * * **FOR OFFICIAL USE ONLY** * * * * *

CONTRAST MEDIA: <input type="checkbox"/> OPTIRAY 320 <input type="checkbox"/> ISOVUE 300 <input type="checkbox"/> ISOVUE 370	AMOUNT INFUSED: _____ CC's
TYPE OF DEVICE: <input type="checkbox"/> JELCO <input type="checkbox"/> BUTTERFLY GUAGE: _____	SITE: _____ # OF ATTEMPTS: _____
INFUSED BY: <input type="checkbox"/> MANUALLY <input type="checkbox"/> POWER INJECTOR: _____	Flow rate: _____ ml/sec; _____ ml/sec
REACTION TO CONTRAST? <input type="checkbox"/> YES <input type="checkbox"/> NO (If YES , see CONTRAST REACTION SHEET)	
REMARKS: _____ _____ _____	
SIGNATURE: _____ RN	