Patient Name: _____
DOB: _____ **Age:** ___ **yrs Gender:** ___
Location: **Community MRI Services NOR**
Exam Date / Exam Time: _____
Exam Reason: _____
Patient Number: _____

Ordering Physician: _____

_____ HEIGHT_____ WEIGHT_____

DO YOU HAVE ANY OF THE FOLLOWING HEALTH CONDITIONS?

ASTHMA	____YES ____NO	HYSTERECTOMY	_____YES ____NO
HEART DISEASE	____YES ____NO	OVARIES REMOVED	____YES ____NO
LUNG DISEASE	____YES ____NO	MASTECTOMY	_____YES ____NO
KIDNEY DISEASE	____YES ____NO	APPENDECTOMY	_____YES ____NO
		KIDNEY REMOVED	_____YES ____NO
HIGH BLOOD PRESSURE	____YES ____NO	COLON RESECTION	_____ YES ____NO
MULTIPLE MYELOMA	____YES ____NO	PROSTATE SURGERY	____ YES ____NO
SWOLLEN ANKLES	____YES ____NO	GALLBLADDER REMOVED	____ YES ____NO
HISTORY OF CANCER	____YES ____NO	LUNG SURGERY	_____YES ____NO

** IF HISTORY OF CANCER-WHAT TYPE OF CANCER _____
ANY OTHER SURGERIES ____YES ____NO _____

PATIENT HISTORY INFORMATION: (IF ANSWER IS YES- PLEASE SPECIFY)

ALLERGY TO IODINE	____YES ____NO	_____
ALLERGIES TO ANY MEDS	____ YES ____NO	_____
ALLERGY TO SEAFOOD	____ YES ____NO	_____
ALLERGY TO STRAWBERRIES	____ YES ____NO	_____
ALLERGY TO IV XRAY CONTRAST	____ YES ____NO	_____
HAVE YOU HAD A PREVIOUS IVP	____ YES ____NO	
OR AN ANGIOGRAM	____ YES ____NO	
ANY REACTION	____ YES ____NO	_____
ARE YOU DIABETIC	____ YES ____NO	

DO YOU USE GLUCOPHAGE,GLUCOVANCE or METFORMIN?____ YES ____NO
Females: Pregnant? Y/N LMP? _____ Nursing? Y/N

TECHNOLOGIST USE ONLY

WITH / WITHOUT CONTRAST
_____CC_____
_____gauge_____

RADIOLOGIST CALLED Y / N____
PROTOCOL_____

EXAM _____
PREVIOUS CT EXAM ____**YES** ____**NO**
CREAT _____
EXAM EXPLAINED ____**YES** ____**NO**
POWER INJECTOR USED ___**YES** ____**NO**
IV LOCATION _____

INFILTRATES ____**YES** ____**NO**
EXISTING IV ____**YES** ____**NO**
CATHETER OUT INTACT ____**YES** ____**NO**
TECH NOTES_____
_____
_____

Patient Name: _____
DOB:_____Age: ___yrs Gender:__
Location:Community MRI Services NOR
Exam Date / Exam Time: _____
Exam Reason: _____
Patient Number: _____

INFORMED CONSENT FOR CAT SCAN (With or Without Contrast Injection)

IF YOU ARE PREGNANT OR THINK THAT YOU MAY BE PREGNANT, PLEASE INFORM THE FACILITY PERSONNEL.

Your physician has requested that we perform a computerized tomography scan (CT) to obtain additional information. This is a diagnostic test that uses x-ray and a computer to produce images of internal body parts.

As part of your examination, we may need to inject you with a contrast solution containing iodine. This clear, colorless liquid is removed from your body by your kidneys and will not alter the appearance of your urine. It will show up on the images to provide important diagnostic information.

Soon after the injection you may experience a metallic taste and a warm sensation. You may feel some nausea. These feelings last only a short time.

Potential Risks:

Occasionally, minor allergic reactions occur in the form of itching, sneezing, hives, swelling of the eyes or wheezing. These symptoms may require treatment with medication we have on hand. It is very important that you inform the technologist if you experience any of the conditions mentioned in this form.

Rarely, a more serious reaction will occur. Even though it is extremely rare, medical statistics indicate that a fatality may occur from the injection of contrast. If you have had a reaction to a contrast injection previously or a history of asthma or other allergic conditions, any history of diabetes or any kidney disorder, anemia or sickle cell anemia, if you are taking Glucophage, Glucovance, Metformin, are pregnant or breast feeding, you MUST inform the technologist.

The benefit of this exam is to assist your physician with making a diagnosis. There may be other imaging alternatives, however, your physician believes the CAT scan to be the best diagnostic test for you after evaluating your symptoms and medical condition.

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to me. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

_____ Date ____ Time _____
Patient/Parent/Legal Guardian Signature

_____ Date _____ Time _____
Witness Signature