

# CT - COMPUTERIZED AXIAL TOMOGRAPHY



- Cascade Medical Imaging, LLC - Eastside
- Cascade Medical Imaging LLC - SCMC Bend
- Cascade Medical Imaging LLC - SCMC Redmond

Today's Date: \_\_\_/\_\_\_/\_\_\_ Name: \_\_\_\_\_ Weight: \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_  Male  Female Referring Dr: \_\_\_\_\_

Briefly describe the problem(s) you are experiencing that made you see your doctor: \_\_\_\_\_

Have you ever had any surgery in the area you are currently having problems?  Yes  No

Type of Surgery: \_\_\_\_\_

Do you have a personal history of cancer in any part of your body?  Yes  No

What **part** of your body and **when** was the diagnosis made? \_\_\_\_\_

PLEASE INDICATE BELOW ANY PREVIOUS PERTINENT STUDIES YOU HAVE HAD, WHEN THEY WERE PERFORMED AND AT WHAT FACILITY:

X-Rays: \_\_\_\_\_

MRI: \_\_\_\_\_

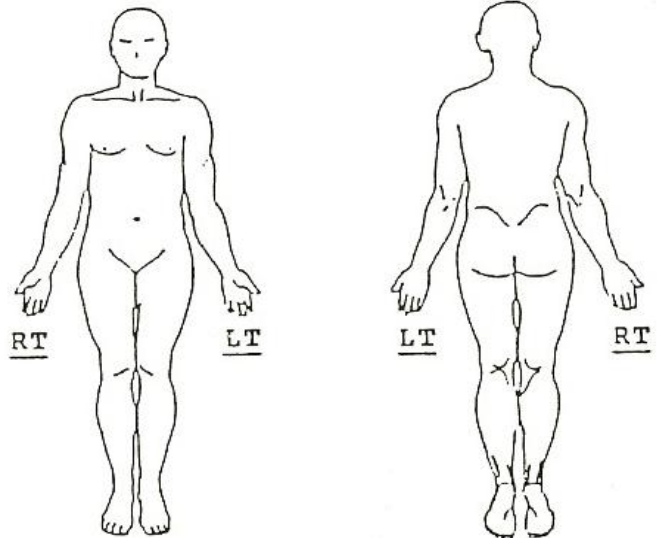
CT Scan: \_\_\_\_\_

Nuclear Medicine: \_\_\_\_\_

Ultrasound: \_\_\_\_\_

Other: \_\_\_\_\_

Please use this diagram to mark where you think your problem is located or where you are feeling pain → → →



## FOR OFFICE USE ONLY

Technologist: \_\_\_\_\_ Contrast Amount Given: \_\_\_\_\_ IV Location: \_\_\_\_\_

Notes: \_\_\_\_\_

PLACE MEDI-TAPE STICKER HERE

# CONSENT FOR CONTRAST MATERIAL INJECTION

CT uses a thin beam of low dose diagnostic x-ray with advanced computer technology to create a series of images that the radiologist reviews. Your physician has chosen contrast CT because it provides an ability to see certain kinds of pathology.

The contrast material is a clear liquid given through a small needle and injected into a vein in your arm. Normally, contrast material is considered quite safe. However, any injection carries a slight risk of harm including injury to a nerve, artery, vein, and infection or allergic reaction. Occasionally the patient will develop sneezing or hives. Uncommonly, (one case in a 1000) a serious reaction to contrast occurs. Very rarely, (one case in 40,000) death has occurred related to the contrast administration. The risk of such a severe consequence is similar to that from the administration of penicillin. Our radiologists and staff are trained to treat these reactions.

Certain patients are at higher risk for experiencing a reaction to the contrast agent. We would like to identify these patients in order to take appropriate measures to try to prevent a reaction. Please fill out the check list below to help us prepare for your CT scan:

- | YES                      | NO                       | Do you have <b><u>ANY</u></b> of the following conditions:                        |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you on dialysis or do you have a history of kidney failure?                   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you had a kidney removed?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you diabetic? (250.00 insulin dependent)                                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a history of cancer or any chronic illness?                           |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a history of heart disease? (V12.50 hx of)                            |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you older than 70?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a history of long-standing or poorly controlled hypertension? (401.9) |

If you are at high risk we may prescribe medicine to be taken during the twelve hours before the injection to try to "block" an adverse reaction. We also use the newer family of contrast agents called "low osmolar" or "non-ionic". X-ray contrast has a long record of safety and effectiveness and these newer agents appear to have a lower incidence of reactions. However, serious reactions can still occur with low osmolar or non-ionic agents. If you have any questions, you are encouraged and expected to ask your CT radiographer or the radiologist.

- | YES                      | NO                       | Do you have <b><u>ANY</u></b> of the following apply to you: |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take Glucophage (Metformin) or Glucovance? (V58.69)   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have asthma? (493.90)                                 |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a known allergy to x-ray contrast? (V15.08)      |

Your signature on this form indicates that:

1. You read and understood the information provided in this form.
2. You have had a chance to ask questions.
3. You have received all information you desire concerning the procedure, and
4. You authorize and consent to the performance of the procedure.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Print Patient Name

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date