St. Charles
MEDICAL CENTER
BEND • REDMOND
2500 NE Neff Road, Bend, OR 97701-6015

Cascade Medical Imaging, LLC

NAME:_____
Place sticker if available
DOB:_____ Age:_____

Sex: F / M

Please check location:
☐ SCMC Radiology Department or ☐ CMI

# RADIOLOGY MEDICATION RECONCILIATION

| **PATIENT TO COMPLETE**: Drugs and/or Contrast Allergies: Yes / No (if yes, list drug & reaction) | Exam Date:<br>Ht: Wt: |
|---|---|
| Name of patient/person providing information:_____Relationship to patient:_____<br>**Signature of patient or responsible party:** | |

| **PATIENT TO COMPLETE: List all current medication (or held for this procedure) including vitamins and herbal supplements** | | |
|---|---|---|
| *Medication, dose, route (Example: Lasix, 10 mg, oral)* | How often do you take it? | Last dose (date/time) |
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**HOSPITAL STAFF TO COMPLETE BELOW:**

Prior to procedure, medication list reviewed by:_____

**Creatinine level/GFR**_____ N/A **IV Location:** Rt. Lt. Hand Wrist Forearm AC **Size:** 24, 22, 20, 18 gauge

**POST PROCEDURE**, HOSPITAL STAFF TO COMPLETE:

**Additional Information**

☐ No changes to medications needed per protocol.

☐ Hold metformin products (Glucophage, Glucovance, Metaglip, Avandamet) for 48 hours after the exam per protocol. Contact your physician to have a Creatinine blood level drawn in 2 days after the exam on (date)_____; your physician will direct you when to restart your metformin related to your lab result.

☐ Resume medications that were requested to be held for your _____ exam.

Other Instructions:

Radiologist Signature:_____

Primary Care Physician Name _____ Fax Number_____ Date Faxed _____