NORTHERN ARIZONA RADIOLOGY

CT Screening Form

Patient name:_____ **Date:** _____

DOB:_____ Age:_____ Sex: ○ M ○ F Height:_____ Weight:_____

Reason for exam/symptoms:_____

Referring Doctor_____

Have you had ANY previous imaging study related to this problem? **Yes** **No**

DATE_____ TEST_____ WHERE_____

DATE_____ TEST_____ WHERE_____

1. List ALL and ANY previous surgeries with dates:_____

2. Check all meds you are taking:

○ Metformin	○ Gumetza Riomet	○ Janumet	○ Avandamet	○ **NONE**
○ Metaglip	○ Actos Plus Met	○ Glucovance	○ Fortamet	

3. List ALL other medications you take _____

4. List all allergies: _____

5. Have you ever had an allergic reaction to an X-Ray/CT Contrast? ○ Yes ○ No

6. Do you have a history of cancer? ○ Yes ○ No Date of diagnosis: _____
   Chemotherapy YES ○ No ○ Dates: _____
   Radiation YES ○ NO ○ Dates: _____

7. **Please indicate if you have ever had any of the following:**

○ Seizures	○ Stroke	○ Implanted medical device
○ Diabetes	○ Hypertension	○ Pacemaker
○ Heart disease	○ History of smoking	
○ Liver disease	○ Asthma	
○ Kidney disease	○ Respiratory disease	
○ Sickle cell anemia	○ Tumor / Lump / Mass	
○ Multiple myeloma	○ Emphysema	

FEMALE PATIENTS

Is there any possibility you are pregnant? YES NO Date of last menstrual cycle _____

Are you currently Breast Feeding? YES NO

PATIENT SIGNATURE_____

Technologist Notes

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Contrast Consent Form

Patient name (print): _____

I understand contrast material will be injected. The indications for and risks of the procedure known as a CT SCAN were discussed with me. The risks were noted to include, but are not limited to, various types of allergic reactions to the intravenous contrast (such as iodinated contrast etc.). Most of these reactions are minor, although they can be severe at times. On rare occasions, inflammation or infection at the site can occur and other more remote risks or consequences may also arise.

I have been advised that if further explanation is desired, I may ask additional questions of the staff to include any supervising radiologists and my referring physician.

_____ _____

Signature of patient or legal guardian Date

_____ _____

Staff witness to signature Date

Female patients:

○ I AM pregnant

○ I am NOT pregnant Last Menstrual Period (LMP): _____

○ I understand I will be receiving x-rays and hereby release all radiologists, respective staff and the facility thereof of any and all responsibility for any adverse reaction to myself and/or damage to my unborn fetus in the event I may be pregnant.

_____ _____

Signature of patient or legal guardian Date