St Joseph's Healthcare System

St. Joseph's Regional Medical Center
St. Joseph's Wayne Hospital
A Division of St. Joseph's Regional Medical Center
St. Vincent's Nursing Home

PATIENT IDENTIFICATION
AFFIX PATIENT LABEL (OR)

PATIENT NAME: _____

DOB: _____

Department of Radiology
Intravenous Contrast Media Questionnaire

Your doctor has ordered a ***CT SCAN*** or ***X-ray***, which requires you to have contrast material (dye) injected into your veins.

During the injection some people feel a warm sensation that lasts a few minutes and then goes away. The following reactions are not seen in everyone, but one or more of them may occasionally occur:

- Nausea, sometimes with vomiting;
- Sneezing
- Itching and hives
- Swelling of the lips and / or around the eyes.

Though extremely rare, you may develop itching or hives several days after the test even though you did not have this reaction on the day of the test. If this should happen please call the doctor who ordered the CT Scan. If the symptoms become worse, or if you develop any difficulty breathing or swelling of the tongue or lips—Go to the nearest Emergency Room for evaluation and treatment.

On occasion but not often, the contrast may leak from your vein into the area around the needle. This may cause some pain and swelling at the injection site. If you feel any pain, please tell the technologist or the nurse.

Extremely rare complications include, but are not limited to: shock, kidney failure, difficulty breathing, cardiac arrest and death.

----------***Please answer the following questions***----------

Have you received contrast material in the past? Yes__ No__ Unknown__

If yes, did you have a reaction? Yes__ No__ Type of reaction: _____

If you had a reaction, were you pre-medicated for today's exam? Yes__ No__

Do you have a history of allergies? No__ Yes__ (Please list) _____ _____

Do you have a history of Asthma? Yes__ No__

If yes, did you take any medication or use an inhaler today? Yes__ No__

Are you a Diabetic? Yes__ No__ If yes, do you take any medication containing metformin?

Glucophage?_____ Glucophage XR?_____ Metaglip?_____ Glucovance?_____ Avandamet?_____

Riomet?_____ Glumetza?_____ ACTOplus met?_____ Fortamet?_____ Other_____

(Note: If patient is taking any of these meds, appropriate Discharge Instructions will be given)

Is there any chance you are pregnant? Yes__ No__ Not sure__

Are you breast feeding? Yes__ No__

Date of Last Menstrual Period _____

This form is required in all instances with the exception of critical tests as defined by radiology policy

RA0100

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Do you have any of the following medical conditions? (Please check all that apply)

- o Multiple Myeloma
- o Poorly controlled Hypertension
- o Sickle Cell Anemia
- o Kidney Disease or Surgery _____
  (type)

  (if on dialysis, date of last treatment)_____
- o Pheochromocytoma
- o Myasthenia Gravis

Medication History: No Meds___ OR Please list all meds you are currently taking, including herbal or over the counter medications _____

_____

FOR THE PATIENT: By signing this form, I certify that the information was correct to the best of my knowledge, and that appropriate education regarding the exam or any aspect of the exam was offered and provided as necessary

Signature of patient (responsible person / guardian) _____

Signature of person reviewing questionnaire _____

Date: _____

TO BE COMPLETED BY RADIOLOGY STAFF

IV Site _____ Gauge _____ Pre-injection Flushed / Patent *(staff initials)* _____

Name of Contrast_____ Lot # _____ Vol. Injected _____

Complete if ANY of the following are present:

❑ infiltration / extravasation Size of infiltration (approx.) _____

❑ contrast reaction[1]

Description of signs / symptoms:_____

_____

_____

_____

_____

Treatment: _____

_____

_____

[1] Any contrast reaction requires reporting in accordance with Pharmacy Policy #6005