

CT HISTORY AND SCREENING: Reference (WDpsiMed#): _____

Today's Date ___/___/___ Patient's Name: _____

Last 4 Digits of SSN _____ Sex: _____ Height _____ *Weight: _____
* (< 450 pounds)

Date of Birth: ___/___/___ Age: _____

Referring Physician _____ Primary Care Provider _____

Please list all known allergies: _____

Reason for today's CT: _____ What are your symptoms: _____

Have you had a previous CT? YES NO

PLEASE ANSWER CAREFULLY, DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

- Yes No Are you currently a dialysis patient?
Yes No Any adverse reaction to CT or IVP contrast material other than a sensation of heat, flushing or a single episode of nausea?
Yes No History of allergy to iodine, shellfish or seafood?
Yes No Heart disease?
Yes No Arrhythmia? (irregular heartbeat)
Yes No Chest pain?
Yes No Recent heart attack?
Yes No Pulmonary hypertension?
Yes No Any severe debilitating disease?
Yes No Sickle cell disease?
Yes No Kidney problems/failure?
Yes No Are you diabetic?
Yes No Are you on Glucophage or Metformin?
Yes No Pheochromocytoma?
Yes No Do you have a history of cancer? If so, what type? _____
Yes No Any previous breast surgery?
Yes No Are you breastfeeding or pregnant? Date of last menstrual period: _____
Yes No Are you currently taking any blood thinners?
Yes No Are you currently taking any diuretics?
Yes No Have you had any of the following removed (please circle) gallbladder ovaries uterus appendix other _____

Please describe any type of surgery that you have had and the approximate date of the procedure:

_____ Date: ___/___/___
_____ Date: ___/___/___
_____ Date: ___/___/___

Will a specialist need a copy of the study you are having today? If yes, please fill in:

Name of specialist: _____

Specialist Address: _____

Specialist phone number: _____

I have answered the above questions to the best of my knowledge and understand the information presented to me regarding CT. I am not pregnant at this time. I consent to CT examination.

Patient's/ Guardian's Signature and Printed Name: _____

Technologist Initials _____

DISCLOSURE AND CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about the recommended procedure to be performed so you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

1. I voluntarily request the physicians, technologists, and other health care providers at Bexar Imaging Center to perform radiological tests on me as ordered by my physician to further evaluate my medical condition.
2. I understand that nonionic (iodine) IV contrast (such as that used for CT scans, IVPs, cardiac catheterizations, and other radiologic exams) will be administered to me if indicated for this procedure.
3. I understand that nonionic IV contrast is associated with the following risks: severe allergic reaction which can lead to death, less severe but still complicated allergic reactions, cardiovascular reactions, hives, shortness of breath, skin damage at the site of the IV, and permanent kidney damage.

Patient's signature or other legally responsible person

Date: _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Counseling physician: David Rotter, M.D. _____

Counseling technologist: Doug Lanford Carlos Herrera Michelle Earl