ONE STEP DIAGNOSTIC
Finally, one step for all your imaging needs

MR #: _____

CT AND IV CONTRAST HISTORY AND SCREENING FORM

Patient Name: _____ Date: _____

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

Referring Physician: _____

Are you pregnant: **YES** **NO** **N/A** Last Menstrual Period: _____

Reason you are here today for an exam:

Explain your medical problem in detail. ***(What happened? Where did it happen? How long have you had this problem?)***

_____

_____

_____

Do you have pain? **YES** **NO** Where? _____

Have you had any surgeries in the area(s) that are being imaged today? **YES** **NO** Where: _____

Have you taken any medication/sedation/alcohol today to help you relax for this procedure? **YES** **NO**

If yes, please list: _____time taken: _____

Have you had a previous exam related to this problem? **YES** **NO** If yes, explain: _____

_____

CONTRAST HISTORY: ☐ **APPLICABLE FOR THIS EXAM** ☐ **NOT APPLICABLE FOR THIS EXAM**

Are you taking Metaformine Hydrochloride (Glucophage, Glucovance)? **YES** **NO**

Have you ever had a previous allergic reaction to x-ray contrast (dye)? **YES** **NO**

If yes, explain: _____

_____

Do you have any of the following? **(circle, if yes, please explain)**

Yes	**No**	Asthma _____
Yes	**No**	Allergic Respiratory Disease _____
Yes	**No**	Diabetes _____
Yes	**No**	Kidney Disease _____
Yes	**No**	Cancer _____
Yes	**No**	Multiple Myeloma _____
Yes	**No**	Prostate Problems _____
Yes	**No**	Are you breast feeding at this time? _____
Yes	**No**	Dizziness _____
Yes	**No**	Heart Disease _____
Yes	**No**	Stroke _____
Yes	**No**	Liver Disease _____
Yes	**No**	Seizure Disorder _____
Yes	**No**	Bladder Disease _____
Yes	**No**	Headaches _____
Yes	**No**	Orthopedic Pins/Rods/Screws/Plates/etc. _____

List any drug allergies: _____

List all surgeries in your lifetime: _____

_____

List all medications you are currently taking: _____

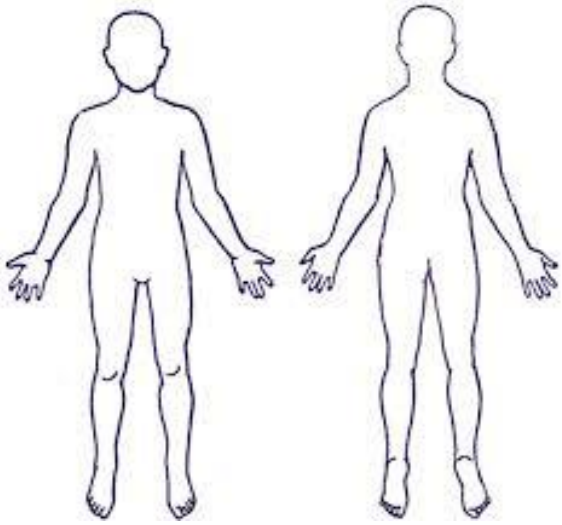
_____

_____

ONE STEP DIAGNOSTIC
Finally, one step for all your imaging needs

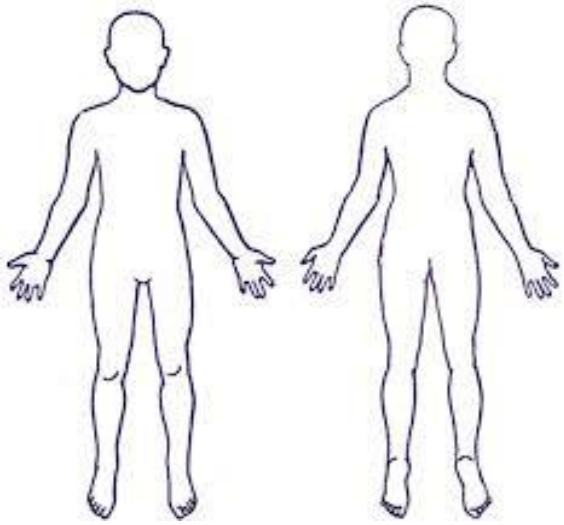
MR #: _____

Draw where your **pain or symptoms** are located on the figure below:



FRONT BACK

Draw the location of **any metal** in your body on the figure below:



FRONT BACK

Acknowledgement: I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that at this time I am **pregnant OR NOT pregnant** (circle)**.**

_____ _____ _____

Patient/Parent/Legal Guardian Signature Technologist Date

**********_For Clinicians Use Only_**********

BUN: _____ Creatinine: _____ or **N/A**

Patient Pre-Exam Education Given: **YES** **NO** Patient Shielded: **YES** **NO**

Clinician Providing Contrast Coverage: _____

Contrast Administration:

_____cc of _____with a _____ @_____×_____

(Needle Gauge & Type) (Time) (Number of Punctures)

By: _____ in _____

(Clinician Signature) (Location of Site)

Lot #: _____ Expiration Date: _____

CT Power Injector Used: **YES** **NO** Rate: _____ cc per_____ seconds

Contrast Reaction: **YES** **NO**

Patient Discharge Instruction Given: **YES** **NO**

Discharge Instruction for Contrast Extravasation Given: **YES** **NO** **N/A**

ONE STEP DIAGNOSTIC
Finally, one step for all your imaging needs

MR #: _____

Computerized Tomography (CT) Consent Form

You have the right to be informed about the recommended diagnostic procedure to be used, so that you may make the decision whether or not to undergo this procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you. It is so that you can choose to give or withhold your consent to the procedure.

If you are pregnant or think you may be pregnant, please inform center personnel at once.

Your physician has requested a Computerized Tomography (CT) examination to obtain additional information. This is a diagnostic test that involves x-ray images and computer to produce an image of internal body parts.

As part of your CT, a contrast agent may be injected into your vein in order to produce better images of the part of the body being examined.

Potential Risks: The following complications are possible anytime an injection is given: potential for pain, bleeding, bruising or swelling at the injection site. CT exams requiring contrast may result in: mild headache, nausea, itching or other vague symptoms for a short time after the injection. Additional allergic reactions in response to the contrast agent may include: hives, shortness of breath or difficulty in swallowing. There have been rare instances of death after the administration of the contrast agent. It is very important that you inform the technologist if you experience any of the conditions mentioned in this form.

If you have previously had a reaction to a contrast injection such as hives, shortness of breath, any significant reaction requiring hospitalization, a history of asthma or other allergic conditions, any history of anemia, sickle cell anemia or kidney disorder; or if you are breastfeeding you must inform the technologist. The safety of contrast in children under 2 has not been established.

The diagnostic test being performed was ordered by your physician based on your symptoms and condition. The benefits of this exam are to assist your physician with a diagnosis.

In conjunction with the American College of Radiology (ACR) guidelines, it is the policy of One Step Diagnostic to identify patients at risk of developing Nephrogenic systemic fibrosis (NSF) prior to any Gadolinium-Based Contrast Agent (GBCA) injection. The method used to identify such patients require assessing renal function at the time of service. Using a point of service device, a serum creatinine level is acquired and used to calculate current estimated Glomerular Filtration Rate (eGFR). If provided, you and/or your insurance company will be billed for this service.

I (WE) CERTIFY THIS FORM HAS BEEN FULLY EXPLAINED TO ME, THAT I (WE) HAVE READ IT, OR HAVE HAD IT READ TO ME (US), THAT THE BLANK SPACES HAVE BEEN FILLED IN AND THAT I (WE) UNDERSTAND ITS CONTENTS. I (WE) HAVE SUFFICIENT INFORMATION REGARDING THE PROCEDURE(S), THE RISKS AND HAZARDS INVOLVED.

Patient Name Printed: _____

Patient Signature: _____

Date: _____Time: _____: _____ AM or PM

Witness Name Printed: _____

Witness Signature: _____

Date: _____Time: _____: _____ AM or PM