NMI NORTHWESTERN MEDICAL IMAGING

CT RADIOLOGY PRE-INJECTION ASSESSMENT

PATIENT NAME_______________________ DATE OF BIRTH______________

PATIENT NO.______________ X-RAY NO.________ HEIGHT/WEIGHT______________

Part of the body to be scanned?______________________________
Have you ever had contrast media (dye) injected? Yes_☐__ No_☐__
Did you have any problems? Yes_☐__ No_☐__
If Yes, what happened? ______________________________
Have you had a recent barium study? Yes_☐__ No_☐__ Unsure_☐__

DO YOU HAVE:

Allergies to Shellfish or Iodine? Yes_☐__ No_☐__ Treatment______________

Other allergies (list): ______________________________

Asthma Yes_☐__ No_☐__ Treatment______________
Emphysema Yes_☐__ No_☐__ Treatment______________
Difficulty Breathing Yes_☐__ No_☐__ Treatment______________
Hay Fever Yes_☐__ No_☐__ Treatment______________
High Blood Pressure Yes_☐__ No_☐__ Treatment______________
Heart Problems (list): Yes_☐__ No_☐__ Treatment______________

Diabetes Yes_☐__ No_☐__
Do you take metformin(Glucophage or Glucovance)? Yes_☐__ No_☐__
Do you use a continuous insulin pump? Yes_☐__ No_☐__
Kidney Disease or Problems (list): Yes_☐__ No_☐__ Treatment______________

Neurological Problems(ie:seizures or stroke)?List_____ Yes_☐__ No_☐__
Liver Disease?List_____ Yes_☐__ No_☐__
Sickle Cell Disease? Yes_☐__ No_☐__
Anemia? Yes_☐__ No_☐__
Multiple Myeloma? Yes_☐__ No_☐__
Organ or Marrow Transplant? Yes_☐__ No_☐__
Are you pregnant? Yes_☐__ No_☐__
Are you trying to get pregnant? Yes_☐__ No_☐__
Are you breastfeeding? Yes_☐__ No_☐__

Medication History: Please list all of the medications, dose and frequency you are currently taking including prescription and over the counter medications as well as herbal supplements.

Patient Signature______________________ **Date**______________

AUTHORIZATION FOR CONTRAST INJECTION

NORTHWESTERN MEDICAL IMAGING
1946 45TH Avenue, Munster, IN 46321

PATIENT NAME:____

Dear Patient:

Your physician has ordered a CT or Computerized Axial Tomography Imaging scan of your _____________________ which can be enhanced by the injection of contrast medium **Berlax Ultravist 300**. This product has been approved by the Food and Drug Administration (FDA) and will be administered intravenously in accordance with its directives (a package insert available upon request) We request that you sign this authorization for permission to perform the injections.

Thank You.

I have read the notice above and authorize the use of this contrast agent.

_________________________ (Signature of Patient)

_________________________ (Date)

_________________________ (Witness)

_________________________ (Technologist)