

PATIENT SCREENING FOR ADMINISTRATION OF IV CONTRAST MEDIA

Height: _____ Weight: _____	Serum Creatinine Level:
1. Have you ever had an x-ray contrast injection for a previous CAT (CT) scan or kidney x-ray or other x-ray?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
If Yes, did you have a bad reaction to it?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
If you had any reaction, what kind was it? <input checked="" type="checkbox"/> all that apply	
<input type="checkbox"/> Nausea or Vomiting <input type="checkbox"/> Swelling (where?) _____ <input type="checkbox"/> Drop in Blood Pressure or Shock	<input type="checkbox"/> Hives <input type="checkbox"/> Trouble Breathing <input type="checkbox"/> Other: _____

2. Please answer the following:	
a. Do you have asthma, chronic obstructive pulmonary disease (COPD) or any respiratory disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
If Yes, do you take medication for asthma or respiratory disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes (everyday) <input type="checkbox"/> Yes (only for attacks)
b. Are you allergic to anything (medicine or food or latex)?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
If Yes, what are you allergic to?	
What happens when you are allergic?	
c. Are you taking any medication for any allergies?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
d. Were you given steroid medication (such as medrol or prednisone) for this test?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
e. Do you have thyroid disease or are you scheduled for a thyroid scan?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
f. Are you pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
g. Are you currently breast feeding or lactating?	<input type="checkbox"/> No <input type="checkbox"/> Yes
h. Are you taking any blood thinners?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know

Any Positive Response to Questions (I – Q) Require Referral to IV Contrast Media Risk Assessment and Management Protocol

i. Do you have heart failure or congestive heart failure (CHF)?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
j. Do you have sickle cell disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
k. Do you have multiple myeloma or history of cancer?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
l. Do you have leukemia?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
m. Do you have kidney failure or kidney insufficiency or had kidney surgery?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
n. Do you have gout or uric acid problem?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
o. Do you have diabetes?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
p. Are you receiving chemotherapy?	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know

q. Are you taking medications for diabetes?

No Yes If Yes, all that apply

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Avandamet® | <input type="checkbox"/> Glucovance® | <input type="checkbox"/> Fortamet® | <input type="checkbox"/> Metformin/Glipzide |
| <input type="checkbox"/> Metformin/Rosiglitazone | <input type="checkbox"/> Riomet® | <input type="checkbox"/> Glucophage® | <input type="checkbox"/> Glumetza® |
| <input type="checkbox"/> Metformin | <input type="checkbox"/> Metformin/Glyburide | <input type="checkbox"/> Glucophage XR® | <input type="checkbox"/> Metaglip |
| <input type="checkbox"/> Pioglitazone/Metformin | <input type="checkbox"/> ActoPlus Met | <input type="checkbox"/> Rosiglitazone/Metformin | <input type="checkbox"/> Other: |

3. Please list any other medications you are currently taking?

Information Obtained from: Patient Medical Record Family

Review Outcome:

- No review triggers identified – OK to Proceed per Protocol
 OK from Physician/Pharmacy to Proceed per Protocol
 Emergency / Waiver signed