Oregon Health & Science University
Hospitals and Clinics
Diagnostic Imaging Services

OC4501

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

PATIENT SCREENING QUESTIONNAIRE FOR INTRAVENOUS CT CONTRAST

To help ensure your safety, please complete this form as accurately and completely as possible

Please provide your current **Height:** _____ **Weight:** _____

Your CT scan requires intravenous (IV) contrast. When the contrast is injected, you may notice a warm or "flushed" feeling throughout your body. This is normal and should go away in 1 or 2 minutes Drink 2 or 3 glasses of water in the first 4 hours after your scan unless your healthcare provider has instructed you to limit your daily fluid intake

In the past 24 hours, have you had a CT scan with intravenous (IV) contrast? (A nuclear medicine bone scan is NOT included)	☐ Yes ☐ No
Are you allergic to CT contrast or any other contrast you were given during an x-ray exam (Angiogram or bladder x-ray exam such as an IVP or VCUG)? **Please describe:** _____	☐ Yes ☐ No
Did you take premedication for a past CT contrast allergy before coming today? **If yes, what time did you take your medication?**	☐ Yes ☐ No
List medication allergies:	
Do you take the medication **Metformin** or medication containing Metformin? Examples: Avandamet, ActoPlus Met, Fortamet, Glucophage, Glucovance, Glumetza, Metaglip, Kombiglyze XR, Prandimet, Riomet, Janumet	☐ Yes ☐ No
Do you have a Central Venous Line? ☐ Port ☐ PICC ☐ Other	☐ Yes ☐ No

Do you have Kidney disease, including		**Do you have**	
Kidney cancer	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No
Single kidney	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No
Kidney surgery or Kidney Transplant	☐ Yes ☐ No	**Female Patients**	
Currently on dialysis	☐ Yes ☐ No	Are you pregnant	☐ Yes ☐ No
Are You		Possibly pregnant or unsure if pregnant	☐ Yes ☐ No
Taking the medication **Hydroxyurea**	☐ Yes ☐ No		
On isolation precautions	☐ Yes ☐ No	Breastfeeding	☐ Yes ☐ No

I have read and understand the contents of this form. I had the opportunity to ask questions about the CT scan I will be having today

Signature of Person Completing Form_____ Date: _____

Relationship to Patient: ☐ Self ☐ Relative ☐ RN ☐ Provider ☐ CT Tech Other_____

Venous Access Information - For OHSU Hospital Inpatient Nursing Staff	
PIV Location: R ☐ L ☐	**Forearm ☐ AC ☐ Upper Arm ☐ Other:**_____
Gauge: 18g ☐ 20g ☐ 22g ☐ 24g ☐	**Power-Rated: Port ☐ PICC ☐ Jugular ☐**
Power-Rated lines Must have positive blood return from ALL LUMENS	
FAX COMPLETED FORM TO 4-6320	