

# North Texas Hospital

## CT Patient Screening Form - Part A

### CT SERVICES PATIENT INFORMATION

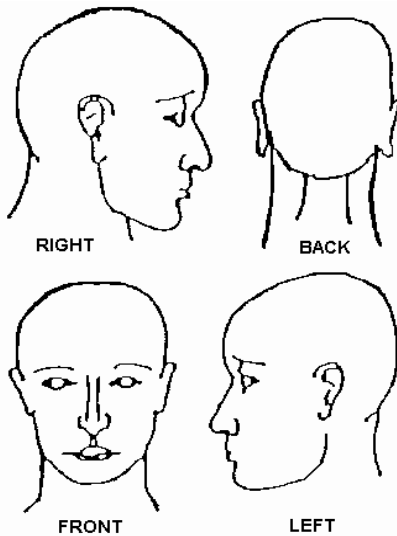
Date of Exam: _____ Time of Exam: _____	Exam Ordered: _____
Patient Name: _____	Date of Birth: _____
Patient Address: _____	Weight: _____ Height: _____
City: _____ State: _____ Zip: _____	Referring Physician/Specialty: _____
Phone Number: _____	Medical Record #: _____
County: _____	Diagnosis: _____
Emergency Contact Name: _____	Phone Number: _____ (cell # if avail.) _____

### PATIENT HISTORY

All "Yes" single asterisked (\*) are to be referred to the radiologist.

<p>* Allergies to IV dye, latex, seafood, shellfish    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>* Diabetes    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>* "I take Glucophage for my diabetes"    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>* Pregnant    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>* Breast Feeding    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>History of Cancer    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Previous Stroke    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Metallic Implant/Prosthesis    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Orthopedic Devices    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Surgical Clips    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>High Blood Pressure    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Irregular Heartbeat    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>	<p>* Multiple Myeloma    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>* Renal Failure    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>* Renal Dialysis    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>* Sickle Cell Anemia    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>* Asthma    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Epilepsy (Seizures)    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Uncooperative or Disoriented    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Claustrophobia    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Unable to Hold Still    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Difficulty Swallowing    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Removable Dental Work    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>Braces    <input type="checkbox"/> Yes    <input type="checkbox"/> No</p>
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Please list previous surgeries \_\_\_\_\_



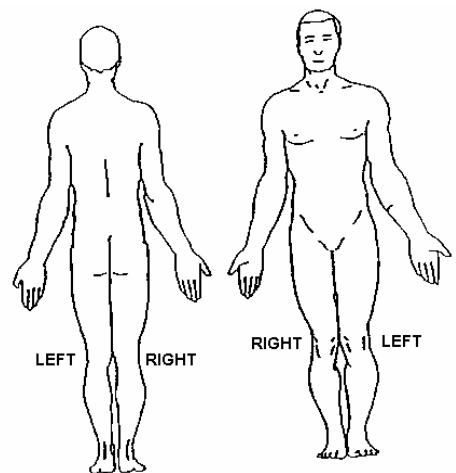
**Check Box below if previous scan completed was similar to body part being examined today**

Previous MRI	<input type="checkbox"/> Yes
Previous CT	<input type="checkbox"/> Yes
Previous PET/PETCT	<input type="checkbox"/> Yes
Previous X-Rays	<input type="checkbox"/> Yes

**If yes Specify Area**

\_\_\_\_\_

\_\_\_\_\_



Using the figures, please shade in the areas affected by pain

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Exam: \_\_\_\_\_

\_\_\_\_\_

# North Texas Hospital

## CT Patient Screening Form - Part B

<b>Patient Name:</b> _____	<b>Date of Birth:</b> _____	<b>Date:</b> _____	<b>Med. Rec. #:</b> _____
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### CONTRAST

Your physician or radiologist may deem it necessary for you to have an IV injection of contrast agent containing iodine to improve the quality of your CT examination. Although iodine contrast agents have been used safely in millions of patients, minor reactions (principally headache, itching, hives, or nausea) may occur. There are rare complications which we consider more serious, including cardiac, renal, and respiratory problems. Despite vigorous emergency therapy, however, fatalities may occur. If you take Glucophage or Metformin for diabetes, you understand you cannot take these medications within 48 hours before and 48 hours after receiving iodine contrast.

I have read and understand the above information, and have had my questions answered. I agree to have the CT procedure and injection of contrast if deemed necessary.

History of previous reaction  Yes  No

Patient Weight: \_\_\_\_\_

If Yes, Explain \_\_\_\_\_ Date: \_\_\_\_\_

**Signature of Patient (Parent or Guardian)** \_\_\_\_\_

### **Pain Screening for Verbal Patients**

Is the patient having pain **before** the exam?

Yes  No

If Yes, Intervention method used for comfort:

(circle) A B C D E F G \_\_\_\_\_

Is the patient experiencing discomfort **during** the exam?

Yes  No

If Yes, Intervention method used for comfort:

(circle) A B C D E F G \_\_\_\_\_

Was the patient's pain and/or discomfort increased **after** the exam?

Yes  No

If yes, instruct patient to contact their physician.

### **Pain Screening for Non-Verbal Patients**

Does the patient have facial expressions or activities that would indicate the patient is having pain **before** the exam?

Yes  No

If Yes, Intervention method used for comfort:

(circle) A B C D E F G \_\_\_\_\_

Is the patient experiencing discomfort **during** the exam?

Yes  No

If Yes, Intervention method used for comfort:

(circle) A B C D E F G \_\_\_\_\_

Was the patient's pain and/or discomfort increased **after** the exam?

Yes  No

If yes, notify a member of the Health Care Team.

Are you allergic to any medications, seafood, or shellfish?

Yes  No If Yes, please list:

1 \_\_\_\_\_ 3 \_\_\_\_\_

2 \_\_\_\_\_ 4 \_\_\_\_\_

Has patient taken any type of medication prior to the exam?  Yes  No

List the medication(s) the patient has taken and all medications patient is currently on.

1 \_\_\_\_\_ 6 \_\_\_\_\_

2 \_\_\_\_\_ 7 \_\_\_\_\_

3 \_\_\_\_\_ 8 \_\_\_\_\_

4 \_\_\_\_\_ 9 \_\_\_\_\_

### Intervention Method Used:

- A. Cushion(s)
- B. Pillow(s)
- C. Talked pt. through exam
- D. Blanket
- E. Modified exam time
- F. Consulted radiologist
- G. Other

BUN: \_\_\_\_\_ Creat: \_\_\_\_\_ IV Contrast  Yes  No Injection Site: \_\_\_\_\_ Injection By: \_\_\_\_\_

IV Contrast Administered: \_\_\_\_\_ Amount: \_\_\_\_\_ ml's Lot# \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Oral Contrast Administered: \_\_\_\_\_ Amount: \_\_\_\_\_ ml's Lot# \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Tech Comments: \_\_\_\_\_

### MINOR MODIFICATIONS BY RADIOLOGIST/PHYSICIAN

Original Exam Order Changed to: \_\_\_\_\_ Changed by: \_\_\_\_\_ Date / Time: \_\_\_\_\_

Discharge Instructions given (applicable to all patients who receive an injection)  
Interviewer (print) \_\_\_\_\_