UCLA Health

CT SCAN – SCREENING QUESTIONNAIRE FOR INJECTION OF INTRAVASCULAR RADIOGRAPHIC IODINATED CONTRAST

MRN:

Patient Name:

Height __________ft _________inches | Weight __________lbs

1. CT Non Contrast **All Patients**	Yes	No	Unknown
Is this safety screening form being waived by MD due to urgency? If yes, enter MD's name ________________________________ MD's pager ID:_____________			
Do you weigh more than 450 lbs.?			
Is there a possibility you may be pregnant? If yes, physician consultation is required.			
• Pregnancy gestational week? _______________			
2. CT With Contrast and/or Interventional CT ****All Patients Receiving IV Contrast****	**Yes**	**No**	**Unknown**
Are you allergic to iodine, or had complication with injected contrast, or have severe multiple allergies? If yes, describe complication:			
• If allergic to iodine, did you receive medication specific to iodine allergy that you were instructed to start prior to the exam?			
Have you ever been diagnosed with asthma or use an inhaler? If yes, please bring your inhaler to the CT scan appointment.			
Do you have a Central Venous Line / PICC Line / Port?			
Do you have symptomatic hyperthyroidism, or scheduled for Nuclear Medicine thyroid scan or radioactive iodine therapy within 6 weeks of planned appointment? If Yes, physician consultation is required.			
Are you currently on dialysis? If yes, please answer the next two questions:			
• Have you been on dialysis for less than 3 months?			
• Is your urine output more than 1 cup a day?			
Have you had kidney surgery or known kidney disease?			
Are you taking medication or injecting insulin to control your diabetes? If yes, please list the medications:			
Are you taking METFORMIN containing medications? If yes, list medications: ____ (Referring MD may withhold METFORMIN drugs 48 hours after scan)			
Have you had or are you being evaluated for solid organ transplant? (liver, kidney, heart, lung)			

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2. CT With Contrast and/or Interventional CT (continued) **All Patients Receiving IV Contrast**	Yes	No	Unknown
Are you taking medication to control high blood pressure or heart failure? If yes, please list the medications:			
Have you ever been diagnosed with myeloma, lupus, scleroderma, and/or rheumatoid arthritis?			
Are you taking anti-inflammatory / pain medications daily (including over the counter) for more than three months - other than Aspirin and Tylenol? (Examples: Advil, Naproxen, Motrin, Ibuprofen)			
Have you had chemotherapy since the last time you had your blood work done to check creatinine or GFR levels?			
3. Cardiac/Coronary CT **All Patients Scheduled for Cardiac CT**	**Yes**	**No**	**Unknown**
Have you ever used beta blockers? If yes, please comment on adverse reactions:			
Are you, regardless or male or female, taking any medications typically used to increase blood flow, for erectile dysfunction syndrome or for pulmonary hypertension such as Cialis, Viagra, Tadalafil, Adcirca? If so, please withhold this medication for 72 hours before the exam.			

This form was completed by (Print Name): ______________________________

Patient or Representative Signature ______________ Date ______________ Time ______________

If signed by someone other than the patient, please specify relationship to patient: ______________

Interpreter Signature ______________ Interpreter ID # ______________ Date ______________ Time ______________

CT Tech/RN Signature ______________ Date ______________ Time ______________

Print Name of CT Tech/RN ______________