DIAGNOSTIC IMAGING CONTRAST QUESTIONNAIRE CONSENT

1. **IV CONTRAST:**
   - Have you had IV contrast media before? ☐ Yes ☐ No
   - Have you had IV contrast media in the last 48 hours? ☐ Yes ☐ No
   - Have you had a prior reaction to IV contrast media? ☐ Yes ☐ No

     If yes, reaction type: ________________________________
   - Are you pre-medicated today? ☐ Yes ☐ No

     List pre-medication: ________________________________
2. **ALLERGIES:**
   - Do you have allergies? ☐None ☐Medications ☐Latex
   - Please list: ________________________________
3. **DAILY MEDICATIONS:** Do you take any medications on a daily basis? ☐ Yes ☐ No
   - If yes please either provide the technologist with a list of these medications or complete the medication reconciliation form. (form M2577)
4. **ASTHMA:** Do you have asthma? ☐ Yes ☐ No
   - If yes, are you currently wheezing? ☐ Yes ☐ No
   - When did you last use your inhaler? ____________________
   - Do you have your inhaler with you today? ☐ Yes ☐ No
5. **DIABETES:** Do you have diabetes? ☐ Yes ☐ No
   - Are you currently taking glucophage, glucovance or metformin? ☐ Yes ☐ No
   - If yes have after care instructions been given? ☐ Yes ☐ No
6. **KIDNEY FAILURE:** (please circle any which apply)
   - Do you have kidney disease/ on dialysis / one (1) kidney / kidney surgery or transplant? ☐ Yes ☐ No
7. **MEDICAL HISTORY:** (please circle any which apply)
   - Have you had multiple myeloma/ myasthenia gravis/ sickle cell/ pheochromocytoma? ☐ Yes ☐ No
8. **FEMALE PATIENTS:**
   - Is there any chance you could be pregnant? ☐ Yes ☐ No
   - Are you currently breastfeeding? ☐ Yes ☐ No

I understand that I will be receiving IV contrast media. All of my questions have been answered to my satisfaction. I wish to proceed with my test, to include the IV contrast injection.

Patient / Guardian Signature: ________________________________ **Date/Time:** __________

Technologist Signature: ________________________________ **Date/Time:** __________

(To be completed by the Technologist)

Lab values (if indicated)

- CREATININE: ________ Date: __________ 1.5 or above requires Radiologist review
- BUN: __________ Date: __________ Radiologist approval required? Yes ____ No ____

Radiologist Signature (if approval is needed): ________________ IV Contrast: Yes ____ No ____

IV size and Site: ________________ # of Attempts: _____ IV Started by: ________________

Was IV Therapy Called? Yes ___No___ # of IV Therapy attempts ____________

Contrast Type/Volume: ________________ Contrast Lot # and Expiration date: ____________

Any reactions noted? Yes ____No ____ If yes, specify: ________________________

IV site at time of removal: No visible problems: ______ Redness: _______ Swelling: _________

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