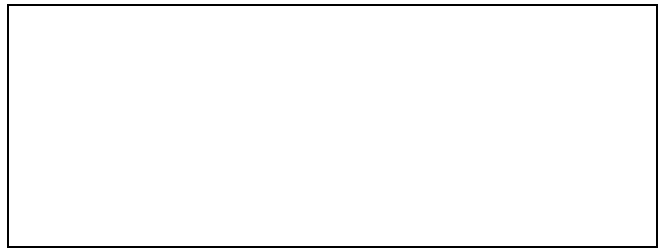




120 S. 6th Street Suite # 155
Minneapolis, MN 55402
Phone: 612-347-7226
Fax: 612-347-7220



Computed Tomography Screening Form

PLEASE COMPLETE THE FOLLOWING:

Male Female

Weight: _____ Height: _____ Age: _____

Date of last menstrual cycle: _____

Are you or could you possibly be pregnant? No Yes

Allergies :(Please list) _____

Have you ever had surgery other than dental? Yes No (Please circle)

Date and Type:

1. Head _____
2. Neck _____
3. Chest _____
4. Abdomen _____
5. Extremities _____
6. Spine _____

Do you have a history of cancer? Yes No (Please circle)

If yes, what is your primary cancer site? _____

Are you being treated with chemotherapy or radiation therapy? (Circle which apply)

Please give us a brief description of your problems or symptoms: _____

How long have you been having these problems? _____

Have you had any other exams related to this current problem or symptoms?

X-rays	No <input type="checkbox"/> Yes <input type="checkbox"/>	When? _____	Where? _____
CT Scan	No <input type="checkbox"/> Yes <input type="checkbox"/>	When? _____	Where? _____
MRI	No <input type="checkbox"/> Yes <input type="checkbox"/>	When? _____	Where? _____
Ultrasound	No <input type="checkbox"/> Yes <input type="checkbox"/>	When? _____	Where? _____
Bone Scan	No <input type="checkbox"/> Yes <input type="checkbox"/>	When? _____	Where? _____
PET Scan	No <input type="checkbox"/> Yes <input type="checkbox"/>	When? _____	Where? _____

Some procedures require the injection of an intravenous contrast material. This contrast contains Iodine. If contrast is required for your exam, we must know the following information about your health:

(Please Circle)

Do you have asthma? Yes No

Do you have diabetes? Yes No

If yes, do you take Glucovance, Metformin or Glucophage? _____

Do you have a heart condition? Yes No

Do you have high blood pressure? Yes No

Do you have kidney failure or kidney problems? Yes No

Do you have Sickle Cell Disease? Yes No

Do you have a form of cancer called Multiple Myeloma? Yes No

Do you have an overactive thyroid gland? Yes No

Have you ever been diagnosed with kidney or adrenal tumors? Yes No

Do you have any other health problems? _____

Have you had anything to eat or drink in the last 4 hours? Yes No (Please circle)

If yes, please describe: _____

Have you had blood drawn within the last 30 days? Yes No (Please circle)

If yes, why/where: _____

Have you ever had a contrast (dye) injected? Yes No (Please Circle)

If yes, did you have any problems with the contrast injection? _____

Explain: _____

Consent For Intravenous Contrast Media Injection

The CT exam you are scheduled for may require the injection of a contrast media or “dye” into a vein. This contrast media contains iodine, which helps to show normal and abnormal structures in the body. The contrast media is a safe and frequently used drug but like all drugs, there can be occasional side effects. The most common side effects are a flushed feeling, upset stomach, or itching. These side effects are usually temporary and require no treatment. Studies show that 1 in 10 or approximately 10% feel one of these side effects. More serious reactions can occur very infrequently. These side effects include shortness of breath, cardiac changes, seizures, kidney failure, shock, blood clots, or tissue damage at the site of injection. Studies show that this type of serious reaction can occur 2 in 1000 or 0.2%. As with many drugs, death has very rarely occurred with contrast media. The chances of this occurring are 1 in 100,000 or 0.001%.

I have directed any questions that I have to the LifeDiagnostics Imaging staff and all of my questions have been answered. I have read the above information and understand the risks and alternatives to the procedure. I consent to have an injection of contrast media for my CT Scan procedure.

Signature: **X** _____ Date: _____

Staff Signature: _____ Date: _____

Consent For CT Scan Procedure

I have read the above information and filled out the screening form to the best of my knowledge. I have directed any questions or concerns to the LifeDiagnostics Imaging staff. I consent to have a CT Scan.

Signature: **X** _____ Date: _____

Staff Signature: _____ Date: _____