

CT Screening

Patient Name: _____

Today's Date: _____ Age: _____ Weight: _____ Height: _____ Sex: M F

	Yes	No	
	<input type="checkbox"/>	<input type="checkbox"/>	If female: is there any possibility you could be pregnant?
	<input type="checkbox"/>	<input type="checkbox"/>	Are you currently breastfeeding?
	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a previous reaction to iodinated contrast media (i.e. CT contrast dye or X-ray dye)? If yes, describe reaction: _____
	<input type="checkbox"/>	<input type="checkbox"/>	If you had a prior reaction to iodinated contrast media, have you been pre-medicated with a corticosteroid (such as Prednisone or Solu-Medrol)? _____
	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any allergies to food or medication? If yes, please list: _____
	<input type="checkbox"/>	<input type="checkbox"/>	Do you have asthma?
	<input type="checkbox"/>	<input type="checkbox"/>	If yes, is your asthma currently affecting you?
△	<input type="checkbox"/>	<input type="checkbox"/>	Do you take Glucophage (Metformin)?
△	<input type="checkbox"/>	<input type="checkbox"/>	Do you have kidney disease or kidney failure or kidney transplant?
△	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a history of kidney cancer or mass?
△	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a family history of kidney failure?
△	<input type="checkbox"/>	<input type="checkbox"/>	Have you previously had kidney surgery?
*	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a recent illness or infection in the past week? Type: _____
*	<input type="checkbox"/>	<input type="checkbox"/>	Have you been feeling sick with nausea, vomiting or diarrhea?

Patient (or legal guardian) signature: _____	Date: _____	Time: _____
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Patient Name (printed): _____	Legal guardian printed name (if applicable): _____
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THIS SECTION IS FOR STAFF USE ONLY

* Serum creatinine within 24 hours △ Serum creatinine within 2 weeks if "Yes" to answer

VASCULAR ACCESS:

DATE _____ TIME _____

TECHNOLOGIST / RN _____

IV SITE _____ 18g 20g 22g ATTEMPTS _____

OTHER _____

CREAT / GFR _____

NOTES _____

PLACE PATIENT LABEL HERE

UW Medicine
 Harborview Medical Center – University of Washington Medical Center
 UW Medicine Primary Care – Valley Medical Center – UW Physicians

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