

Contrast Medication Screening Form
CT/MRI/XR

Please Complete and Sign: Your physician has determined that it is medically indicated and necessary to use an intravenous injection of contrast medication either iodinated or gadolinium in performing a radiographic examination. Please complete the section below concerning your medical history. A Bright Light Radiology Associate will review the information with you once completed.

Patient Name: _____

Medical Record No: _____

- Yes No Prior IV Contrast Medication (CT, IVP, Angiogram)
- Yes No Adverse reaction to IV Contrast Medication. If yes, please provide details.

- Yes No History of Kidney problems?
- Yes No History of Diabetes?
- Yes No Pheochromocytoma?
- Yes No History of Asthma?
- Yes No Allergies? If yes, please provide details.

- Yes No Cancer and Chemotherapy?
- Yes No Renal/Kidney Disease? If yes, please provide details.

- Yes No Hemodialysis / Renal Dialysis?
- Yes No Liver Transplant or Liver Disease?
- Yes No Sickle Cell Disease?
- Yes No Multiple Myeloma?
- Yes No Heart Disease? If yes, please provide details.

- Yes No Pulmonary Disease? If yes, please provide details.

- Yes No Pregnant? If yes, how many weeks? _____
- Yes No Breast Feeding?

Medications Screening

- Yes No Patient receiving Propranolol (**Inderal[®]**, **Inderal LA[®]**, **InnoPran XL[®]**)?
- Yes No Patient receiving Amiodarone (**Parcerone[®]**, **Cordarone[®]**)
- Yes No Did you take pre-medications for this procedure?
- Yes No Patient receiving **Metformin** or **Metformin containing product**. If yes, check one and give the date and time of last dose.
 - Metformin-Fortamet[®], Glucophage[®], Glucophage XR[®], Glumetza[®]**
Date: _____ Time: _____ am/pm
 - Glipizide/Metformin-Metaglip[®]**
Date: _____ Time: _____ am/pm
 - Glyburide/Metformin-Glucoavance[®]**
Date: _____ Time: _____ am/pm
 - Pioglitazone/Metformin-ActoPlus[®]**
Date: _____ Time: _____ am/pm
 - Rosiglitazone/Metformin-Avandamet[®]**
Date: _____ Time: _____ am/pm

Medication Warning: Metformin or Metformin containing products have been associated with an increased risk of lactic acidosis. If a patient is taking Metformin product it must be withheld for at least **48 hours** following IV contrast administration and resumed only after confirming a stable BUN and Creatinine level from a 48 hour blood test ordered by your referring physician.

To the best of your ability, please list all your current medications (Prescription, over-the-counter medications, herbal supplements and vitamins)

Drug Name	Dose	How do you take it?	How often?	Last Dose Taken? Date/Time

Patient having a CT Scan:

I understand iodinated contrast material will be injected. The risks may include, but are not limited to, various types of allergic reactions. Most of these reactions are minor, although they can be severe. On rare occasions, inflammation or infection at the site can occur and other more severe consequences may also arise.

Patient having an MRI:

I understand contrast material will be injected. The contrast agent used in an MRI is called Gadolinium. A small number of patients receiving this contrast may develop a headache and experience nausea. Rarely, local inflammation or irritation may occur at the injection site

Patient Signature: _____

Date: _____

Medical Imaging Personnel to Complete

Information Reviewed by: _____

Serum Creatinine Value: _____ **GFR:** _____

Contrast Administered: _____ **Amount:** _____ **IV Location/ Gauge:** _____

Radiologist will reassess need for IV contrast if answered YES to any of the above potentially harmful conditions or medications.

Recommendation: _____

Radiologist Signature: _____

Date: _____