

+ STAT "Place X IN BOX IF STAT"

+

Name: _____

Sex: Male Female Date of Birth _____

Allergies: _____

Check if Allergy Pre-Medication Protocol Followed:

Date of Pre-Medication Protocol: _____

Height: _____ (ft or cm) _____ (in) Weight: _____ (lbs) (kg)

Race: Black White Hispanic Asian Other

What symptoms brought you to the center? _____

Were you injured? YES NO N/A How? _____ When? _____

PATIENT HISTORY

Have you experienced any of the following? (for Outpatients and Emergency Center patients only)

Inpatient Outpatient ER Patient

YES NO

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Renal (kidney) Disease * †

Renal (kidney) Surgery *

Diabetes * †

Gout *

Multiple Myeloma * †

Seizures

Any serious allergic reactions to anything? †

Liver transplant/pending liver transplant?*

Use of Metformin(Glucophage, Glucovance, etc.)*

Have you received contrast media prior to this exam?

If yes, did you have a reaction to the contrast agent? † Describe reaction: _____

Are you currently on Dialysis? †

Have you had a MRI with a contrast injection in the past 7 days?

YES NO

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Proteinuria (protein in the urine) *

Hypertension (high blood pressure)*

Asthma †

Congestive Heart Failure †

Glaucoma

Sickle Cell disease †

History of Hepatitis

History of Cancer Type: _____

Prior Surgery Type: _____

KEY: * = GFR calculation is required if yes
† = May authorize Visipaque if yes

Medication History (for outpatients and Emergency Center patients only)

Inpatient medication reviewed by Pharmacist

Please provide information about each prescription medication, herbal supplement, over the counter (OTC) medication that you are currently taking.

DRUG NAME	DOSE STRENGTH/QUANTITY	ROUTE (ORAL,IV, ETC.)	HOW OFTEN	LAST DOSE DATE /TIME
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Patients with Diabetes

If you are taking Metformin (Glucophage, Glucovance, etc.) and having a contrast injection in X-ray or CT today, you will be asked to stop taking it for 48 hours post injection of contrast media. This does not apply to MRI contrast injections. Contact your primary physician prior to restarting your Metformin (Glucophage, Glucovance, etc.) to make sure your renal functions are okay.

I will stop my Metformin (Glucophage, Glucovance, etc.) and contact my physician before restarting it. _____ (Initial Here)



Patient History/
Pre-IV Contrast Form



FEMALE PATIENTS

YES NO

- Have you ever had a hysterectomy?
- Were your ovaries removed?
- Do you have an IUD?
- Do you use birth control pills?
- Tubal Ligation
- Do you have a positive pregnancy test now?
If yes, by: Blood Urine
If yes, when did you test positive: _____

YES NO

- Any possibility that you are pregnant?
Date of last menstrual period? _____
- Total pregnancies: _____
- Miscarriages: _____

OFFICE USE ONLY

Contrast Media Requested: Check Dose

- 50ml 100ml 150ml Omnipaque
- 50ml 100ml 150ml Visipaque
- 10ml 20ml 50ml 100ml Normal Saline
- Lot #: _____ Other Dose: _____ ml

Route of administration is IV: Frequency is once

- _____ ml Omniscan (Gadolinium Other dose _____ ml)
- _____ ml Magnevist Lot# _____

Pregnancy Test Results: Positive Negative (Reference range; Negative) Date/Time Collection: _____

iStat used YES NO

Creatinine: _____ 0.5 - 1.4 mg/dl Date/Time Collection: _____ Estimated GFR: _____ ml/min/1.73m²

Glucose: _____ 70 - 99 mg/dl Date/Time Collection: _____

Is the patient taking Metformin or Metformin containing drugs Yes No

Name of Radiologist who approved giving contrast if applicable: Dr. _____
30 or Below for CT / X-Ray and 60 or below for MRI

Name of Nephrologist who approved giving contrast if applicable: Dr. _____
30 or Below for MRI

Patient is being hydrated before and after administration of contrast. Yes _____ MD initial (For CT/X-Ray below 30)

Physician Signature: _____ Print Name: _____ Date/Time: _____

Pharmacist Approval: Yes No

Pharmacy Review – in down time, fax to _____ Follow up with a call to _____

Pharmacy Signature: _____ Print Name: _____ Date/Time: _____

FAX BACK TO

MRI	CT	X-ray	OPID CT
X _____	X _____	X _____	X _____

Dept. Phone:			
X _____	X _____	X _____	X _____

Technologist Comments:

Yes No Is this patient a suspected victim of abuse? Yes No Is this patient a fall risk?

Yes No Patient tolerated exam Yes No Patient discharged without complaint

COMMENTS: _____

Technologist / Nurse Signature: _____

Print Name: _____

Date/Time: _____

**MEMORIAL
HERMANN**

**Patient History/
Pre-IV Contrast Form**

