STAR IMAGING

PATIENT HISTORY AND IV CONTRAST CONSENT FORM

Patient Name _____ Date _____

Date of Birth _____ Age _____ Weight _____ Sex ☐Male ☐Female

		YES	NO
1.	Medication Allergies? Please List _____	☐	☐
2.	IV Iodine or any food allergies (if yes please list) _____	☐	☐
3.	Previous Surgeries (if yes please list)_____	☐	☐
4.	Have you ever been given contrast material that contains Iodine for X-ray or CT?	☐	☐
5.	Have you had a CT with contrast in the last 24 hours?	☐	☐
6.	Any history of (circle all that apply): Multiple Myeloma or Sickle Cell Disease, Kidney Disease, Kidney Failure, Liver Disease?	☐	☐
7.	Hypertension?	☐	☐
8.	Are you Diabetic?	☐	☐
9.	Do you take Glucophage (Metformin), Metaglip, Glucovance, Avandamet, Actoplus?	☐	☐
10.	Any History of Cancer? If yes, what kind? _____	☐	☐
11.	Do you have Asthma?	☐	☐
12.	Any chance of pregnancy?	☐	☐

The imaging test that has been ordered by my physician has been explained to me and I understand that it involves an injection of contrast material into the vein. I have been advised of and understand the risks and adverse reaction(s) associated with use of intravenous contrast materials. I consent to the injection of a contrast agent deemed necessary by my physician and the Radiologist.

I have had the opportunity to ask questions regarding the test and all my questions have been answered to my satisfaction. I agree to the intravenous injection of contrast material.

Patient Signature _____ **Date:**_____

FOR TECHNOLOGIST USE ONLY

Reason for exam_____

0.9% Sodium Chloride: Lot #_____ Exp Date: _____ Volume: _____

BUN: _____ **CREATINE:** _____ **EGFR:** _____ **Injection Site:** (R) (L) _____

Contrast Injected: Omnipaque 300 350 Lot #_____ Exp Date: _____ Volume: _____

Oral Contrast: Omnipaque 300 (Y) (N) Lot #_____ Exp Date: _____ Volume: _____

Technologist: _____ **Date & Time:** _____