COMPASS HEALTH

SETTING A NEW DIRECTION IN HEALTH CARE

2175 Coolidge Road

East Lansing, Michigan 48823

Phone (517) 999-5900

CT Screening Form

Patient Name:________________________________ Date of Birth___________________________ Male/Female

Weight:____________lbs Appointment Date/Time: ______________Scheduled Exam___________________________

Chief Complaint/Reason for seeing your doctor: ____

____

How long have you had these symptoms? ____

Previous surgeries on area of interest: ____

Previous radiological exams (ultrasound, MRI, x-ray, etc) on area of interest: (Please state when and where if applicable):

____

Please list all allergies: ____

____

Please check the appropriate box on whether or not you have the following:

Yes	No		Yes	No	
☐	☐	IV dye/latex allergy	☐	☐	Do you have both kidneys?
☐	☐	Asthma/Hay Fever	☐	☐	Heart problems
☐	☐	Renal Failure	☐	☐	High Blood Pressure
☐	☐	Kidney Disease	☐	☐	Asthma/Hay Fever
☐	☐	Diabetes	☐	☐	Sickle Cell Anemia
☐	☐	Previous contrast reaction	☐	☐	History of cancer
		If yes, explain:			If yes, explain:

If **Diabetic**, do you take Metformin Medications (Glucophage, Glucovance, Avadament, Metaglip, Fortamet, or Riomet)? If YES, please DO NOT TAKE YOUR METFORMIN MEDICATIONS FOR 48 HOURS AFTER RECEIVING IODINE CONTRAST INJECTION.

Female Patients Only- Your test will normally be rescheduled if there is any chance of pregnancy.

Is there any possibility you may be pregnant? Yes No Last Menstrual Cycle: _______________

____

Patient/Legal Guardian Signature *Today's Date*

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Radiology Use Only

Further Comments: ____

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Creatinine Level: _________________ GFR: ______________ Draw Date: __________________

Contrast Used: Omnipaque 300 Omnipaque 350 Oral Barium Sulfate Other _______

Volume: __________ Rate: ___________ IV Site: _______________ Reaction: Yes No (If yes, fill out reaction form)

# of Images: __________