Perth and Smiths Falls District Hospital
Patient History Form---CT

Name: _____ **Weight:**_____

Pregnancy Risk Assessment (females, 12 – 55 yrs) by: _____ MRT(R)
□ BCM □ Other

□eGFR less than 30 □ Confirmation Medical Directive followed N/A (please note changes)

Do you have a history of problems with any of the following?

History	Yes	No	Comments
Heart			
Blood Pressure			
Diabetes Mellitus			
Kidney Disease			
Blood Disease			

Have you ever had an injection of X-ray Contrast/Dye? Kidney x-ray, CT scan, Angiogram

Yes No Any problems? _____.

Do you have any Allergies? **Patient pre-medication required? No Yes □ Confirmed Med Dir followed**

Medications/Drugs

X-ray Contrast

Date:

Verbal Consent obtained by:

History Provided by:

IV gauge: Injection Site: IV Inserted by:

Contrast: **Omnipaque 350** Injected by:

Injection Time: Volume: Rate:

Comments:

Metformin Protocol:
Info provided/explained by:

Faxed to Physician by:

Created: 04/2010 Revised 03/26; 12/2016; 05/2014; 07/2013; 01/2013; 08/2012; 08//2011