CT - Part A

Factors such as weight, body shape and scan type may determine if scan can be performed.

Last Name _____

First Name _____

Date of Birth _____ **Date** _____

Patient: Please complete all the information contained in this boxed area.

Patient Stated Weight: _____lbs/kgs Height: _____

Please list previous surgeries and their dates: _____

_____

PATIENT HISTORY

Medical/Dental Procedures with Sedation in the past 24 hours? ❑ Yes ❑ No

**** Pregnant** .....❑Yes ❑ No
Last Menstrual Period Date _____
*** Breast Feeding**.....❑ Yes ❑ No
*** Personal history of Diabetes**.....❑ Yes ❑ No
*** Allergies to IV dye**.....❑ Yes ❑ No
*** Multiple Myeloma**.....❑ Yes ❑ No
*** Sickle Cell Anemia** .....❑ Yes ❑ No
*** Pacemaker** .....❑ Yes ❑ No
*** Infusion Pump** .....❑ Yes ❑ No
*** Neurostimulator** .....❑ Yes ❑ No
*** Implanted or External Medical Devices** ❑ Yes ❑ No
Asthma/COPD/Emphysema.....❑ Yes ❑ No
Irregular Heartbeat.....❑ Yes ❑ No
History of diarrhea in past 2-3 days.....❑ Yes ❑ No
Any Falls within the past 30 days.....❑ Yes ❑ No
If yes, most recent fall date: _____

History of Cancer.....❑Yes ❑ No
What Type _____
Chemotherapy _____ **Radiation** _____
Previous Stroke.....❑Yes ❑ No
Metallic Implant/Prosthesis.....❑Yes ❑ No
Orthopedic Devices .....❑Yes ❑ No
Surgical Clips.....❑Yes ❑ No
Epilepsy (Seizures).....❑Yes ❑ No
Catheter or Drainage Tube.....❑Yes ❑ No
Claustrophobia .....❑Yes ❑ No
Difficulty Swallowing.....❑Yes ❑ No
Dental Braces.....❑Yes ❑ No
Removable Dental Work.....❑Yes ❑ No

Did you self-medicate
for today's procedure? ..... ❑ Yes ❑ No
If yes, do you have a driver? ❑ Yes ❑ No

Any previous imaging study related to the reason for today's exam? ..... ❑ Yes ❑ No

Type of Exam _____ Facility _____Date _____

I understand the risk of having an x-ray while pregnant and I do not believe I am pregnant.

Initial:_____ Date: _____

Signature of Patient:_____ **Date:**_____**Time:** _____

(*Parent or Guardian if patient is a Minor or Incapacitated*)

Relationship:_____

(**) Pregnancy requires signed informed consent. Single asterisk (*) items may require further discussion between Technologist and Radiologist. Document any verbal approvals or instructions on Part B.

Tech Comments: _____

_____

I have reviewed each response with the patient or their legal guardian, power of attorney, next of kin, etc. and PERFORMED CLINICAL PAUSE #1.

Technologist Signature: _____ **Date:** _____

CT - Part B

Medical Record # / Accession #: _____

Exam Ordered - CT of: _____

Facility Name: _____

Referring Physician: _____

Diagnosis: _____

Reason for Exam/Clinical Symptoms: _____

_____

Last Name _____

First Name _____

Date of Birth _____ **Date** _____

Clinical Pause #1:
Correct Patient ☐ Correct Imaging Protocol ☐
Correct Body Part ☐ Correct Procedure ☐
At or Below Dose Threshold ☐ Correct Positioning ☐
Tech Initials _____

Patient's preferred language for discussing healthcare: ❑ English ❑ Spanish ❑ Other

Is the patient allergic to any medications, seafood, shellfish, or latex?
❑ Yes ❑ No If Yes, please list:

_____

List all current medication(s) and check the ones taken today:
(Include birth control and over the counter, ointments, herbals, vitamins, medication patches, etc.)

_____ ❑ _____ ❑
_____ ❑ _____ ❑
_____ ❑ _____ ❑
_____ ❑ _____ ❑

❑ Patient unaware of current medications ❑ Patient not on any medications
❑ Medication list attached (Includes name & DOB)

Oral Contrast Name _____
Amount _____ mL
Lot # _____
Exp. Date _____
Administered By: _____
Title: _____

Barriers to Learning ❑Yes ❑No

Type:	Intervention:
❑ Language	❑ Interpreter ID# _____
❑ Hearing	❑ Repeat Questions
❑ Other _____	❑ Family/Significant Other

Will the Patient receive an IV injection? ❑ Yes ❑ No If yes, A054(a) must be completed and signed.

Injection site evaluated? ❑ **Yes** ❑ **No** ❑ N/A **Note appearance** _____

Post Injection Instructions given (applicable to all patients who receive an injection). ❑ Yes ❑ No ❑ N/A

RECEIPT OF VERBAL ORDERS, TEST RESULTS, MODIFICATIONS, OR OTHER INSTRUCTIONS ❑ Yes ❑ No

Information Received: _____

Readback confirmed with _____ Title _____ Date _____ Time _____

Technologist Signature: _____ Date _____ Time _____

Radiologist Signature: _____ Date _____ Time _____

Patient was encouraged to "Speak up" with questions or concerns. ❑ Yes ❑ No

If retail, Patient Rights & Responsibilities provided to the patient. ❑ Yes ❑ No ❑ N/A

Technologist Comments _____

_____

CTDI _____ mGy **DLP** _____ mGy-cm **Anatomy** _____

CTDI _____ mGy **DLP** _____ mGy-cm **Anatomy** _____

Dose at or below threshold? ❑ Yes ❑ No If no, why? _____

If over threshold, was CT Log completed? ❑ Yes ❑ No

Clinical pause #2 prior to image transfer (Correct labeling, annotation and image quality)? Tech Initials _____

Prior to release, patient was assessed and found impaired? ❑ Yes ❑ No If yes, supervising physician notified? ❑ Yes ❑ No
If patient refuses further assessment, notify supervising physician and Team personnel to follow policy #5023.

Team Member Signature and Title: _____

PATIENT SIGNATURE BELOW ONLY AT THE COMPLETION OF EXAM.

I retrieved all of my personal belongings upon completion of exam. ❑ Yes ❑ No ❑ N/A
I give my consent to receive communication/survey via text or e-mail. ❑ Yes ❑ No ❑ N/A
(Data rates may apply depending on your mobile carrier.)
Preferred Method of Communication: ❑ Cell ❑ E-mail
Cell #: (_____) _____ **E-mail:** _____
I have received a copy of the terms and conditions for electronic communication.
❑ Yes ❑ No ❑ N/A **Patient Signature** _____