CT Screening

Patient Name:_____

Today's Date:_____ Age:_____ Weight:_____ Height:_____ Sex: ☐ M ☐ F

What is the reason this exam was ordered?_____

Allergy Information

Yes	No	
☐	☐	Are you allergic to iodine, IVP dye or x-ray/CT contrast? If yes, what was your reaction?_____
☐	☐	If you have a known allergy to x-ray/CT contrast, did you take prednisone and/or Benadryl last night and today?
☐	☐	Do you have any other allergies? If yes, please explain:_____
☐	☐	Do you have asthma? If yes, is it currently affecting you? _____

Renal (Kidney) Health Related Information

Yes	No	
☐	☐	Do you have kidney disease or kidney failure?
☐	☐	Have you had a kidney transplant?
☐	☐	Have you previously had kidney surgery?
☐	☐	Do you have a family history of kidney failure?
☐	☐	Do you have a history of kidney cancer or mass?
☐	☐	Have you been feeling sick with nausea, vomiting, or diarrhea?

Other

Yes	No	
☐	☐	Female: Is there any chance you could be pregnant?
☐	☐	Do you take medication for high blood pressure?
☐	☐	Do you take Glucophage (Metformin)?
☐	☐	Do you have Diabetes?
☐	☐	Do you have any other pertinent medical history? Please explain briefly.

_____

_____

_____ _____ _____

Patient Name (printed) Patient (or legal guardian) Signature Date Signed

_____

If signed by person other than patient, provide printed name, relationship to patient, description of authority

This Section for Hospital Use	
Date:	MRN:
Creatinine: GFR:	Lab Date:
If GFR is less than 30, notify physician.	
Name:	Date:

PLACE PATIENT LABEL HERE

UW Medicine
Harborview Medical Center – Northwest Hospital & Medical Center
Valley Medical Center – UW Medical Center
University of Washington Physicians Seattle, Washington

CT SCREENING

U2359

UH2359 REV FEB 19