

HARMONY IMAGING CENTER, LLC

Poudre Valley Health System

A joint venture between Poudre Valley Health System and Fort Collins Radiologic Associates, P.C.

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Your doctor has ordered an exam that may require a special dye that shows up on x-ray to be injected into a vein. Sometimes, a patient will have a mild reaction to the dye and develop nausea, sneezing, flushing of the skin and hives. Uncommonly, (1 case in 1,000) a more serious reaction to the dye can occur. The physicians and staff of this Radiology Department are trained to treat these reactions.

Please answer all the following questions to the best of your knowledge. The answers will help the Radiologist and technologist tailor your exam to allow for the shortest, safest and most accurate exam possible. If you need help filling out this form, please ask the nurse or technologist to help you.

Today's date: _____ Patient Name: _____

Type of exam (circle all that apply) IVP CT OTHER _____

Please list your main symptoms that caused the doctor to order the exam(s) that you are having today. _____

1. Have you had x-ray dye before? **YES NO**

If yes, when? _____

Did you have any itching, hives, swelling of the throat or face, difficulty breathing or heart problems when you had the dye? **YES NO**

2. Do you have asthma or reactive airway disease? **YES NO**

If yes, do you use an inhaler? **YES NO**

What kind? _____

How often? _____

Do you have your inhaler with you today? **YES NO**

3. Do you have diabetes? **YES NO**

If yes, do you take Glucophage or Glucovance? **YES NO**

4. Do you have kidney failure? **YES NO**

If yes, are you on dialysis? **YES NO**

5. Do you have any food or medicine allergies? **YES NO**

Circle all that apply:

Iodine Penicillin Codeine Sulfa drugs Aspirin Anesthetic

Vaccine Seafood Other _____

6. Do you have any environmental allergies? **YES NO**

Circle all that apply

Latex Dust Molds Dander Other _____

7. Do you take Coumadin or other blood thinner? **YES NO**

8. When was the last time you had food or drink? _____

9. Have you ever had cancer? **YES NO**

If yes, list areas involved: _____

Did you have chemotherapy? **YES NO**

When? _____

Did you have radiation? **YES NO**

When? _____

10. Have you ever had surgery on any of the following areas? **YES NO**

(Circle all that apply, write in dates also)

Brain _____ Sinus _____

Prostate _____ Appendix _____

Ovary _____ Stomach/Abdomen _____

Heart _____ Colon _____

Breast _____ Gallbladder _____

Lung _____ Neck _____

Other _____

Patient Identification

Are you pregnant?
Date of last menstrual period _____

YES NO

I have read and understand the questions and answered them to the best of my knowledge.

Signature of client or authorized representative

Date

TO BE COMPLETED BY TECHNOLOGIST

Serum Creatinine/BUN results: _____ Date: _____

Contrast type: _____ Amount injected: _____ Lot number: _____

CT Protocol used _____

Contrast Reaction: **YES NO** If **YES**, describe: _____

Extravastation **YES NO**
Nurse/Physician notified **YES NO**

Comments: _____

Tech Signature: _____

Date: _____

TO BE COMPLETED BY RADIOLOGY NURSE

IV/BC started: Site _____ Guage _____

Contrast Pre-medication taken? **N/A** **YES** **NO**

If checked "NO", reason why pre-medication was not taken? _____

What follow up/tracking was done? _____

Patient taking Glucophage/Glucovance? **YES NO**
Glucophage teaching done? **YES NO**

BUN/CREAT lab requisition given to client (to be drawn in 48 hours)? **YES NO**

Attending physician notified? **YES NO** Dr. _____ Phone _____

Client instructed to hold Glucophage until attending physician instructs client to resume? **YES NO**

Comments: _____

Nurse Signature: _____

Date: _____