CT Patient Screening Form - Part A

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

Patient Label or Accession Number

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

Patient Name (Last, First):_____ Date of Birth: _____

Patient Address: _____ Date of Exam: _____

City, State, Zip: _____ Patient Stated Weight: _____lbs/kgs Height:_____

Please list previous surgeries and their dates: _____

_____

PATIENT HISTORY

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

**** Pregnant** ❑ Yes ❑ No
*** Personal history of Diabetes** ❑ Yes ❑ No
*** Allergies to IV dye or latex** ❑ Yes ❑ No
*** Breast Feeding** ❑ 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
History of High Blood Pressure ❑ Yes ❑ No
If yes, is it now controlled with medication? ❑ Yes ❑ No
Irregular Heartbeat ❑ Yes ❑ No
History of recent diarrhea in past 2-3 days ❑ Yes ❑ No
History of 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
Uncooperative or Disoriented ❑ Yes ❑ No
Claustrophobia ❑ Yes ❑ No
Unable to Hold Still ❑ Yes ❑ No
Difficulty Swallowing ❑ Yes ❑ No
Removable Dental Work ❑ Yes ❑ No
Braces ❑ 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: _____

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

Medical Record # / Accession #: _____ Facility Name: _____

Exam Ordered - CT of: _____ Referring Physician/Specialty: _____

Diagnosis: _____

CTDI _____ mGy

DLP _____ mGy-cm

Reason for Exam/Clinical Symptoms: _____

_____

I have reviewed this information with the patient or their legal guardian, power of attorney, next of kin, etc. and performed a clinical pause.

Technologist Signature: _____ **Date:** _____

CT Patient Screening Form - Part B

Patient Label or Accession Number

Patient Name (Last, First): _____

Date of Birth: _____ **Date:** _____

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

Clinical pauses conducted prior to exam **AND** prior to image transfer.

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:

1 _____ 3 _____

2 _____ 4 _____

Oral Contrast Name_____

Amount _____ mL

Lot #_____

Exp. Date_____

Administered By: _____

Title:_____

List any medication(s) the patient has taken today and all current medications:

(Include birth control and over the counter, ointments, herbals, vitamins, medication patches, etc.)

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

4 _____ 9 _____

5 _____ 10 _____

Barriers to Learning ❑Yes ❑No

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

❑ Patient unaware of current medications ❑ Patient not on any medications

Did patient self-medicate for today's procedure? ❑ Yes ❑ No

If yes, do they have a driver? ❑ Yes ❑ No

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 Alliance personnel to follow policy #5023.

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

Comments: _____

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

Information Received: _____

Readback confirmed with _____ Title _____ Date _____ Time _____

Technologist or Radiologist Signature: _____ Date _____ Time _____

Post Injection Instructions given (applicable to all patients who receive an injection).	❑ Yes	❑ No	❑ N/A
Patient notified of rights and opportunity to "Speak up" with questions or concerns.	❑ Yes	❑ No	
Handoff Report given to next provider of care. Medication list provided if applicable.	❑ Yes	❑ No	❑ N/A
If retail, Patient Rights & Responsibilities provided to the patient.	❑ Yes	❑ No	❑ N/A

Dose reduction technique utilized. ❑ Yes ❑ No If no, why?_____

Are patient reminder calls for this site made by Alliance Team Members? ❑ Yes ❑ No ❑ EMR

If yes, to above and NOT documented in an EMR or Intergy, complete row below.

Team Member Name: _____ Date: _____ Time: _____

Summary: _____

Technologist Comments _____

Team Member Signature and Title:_____

PATIENT SIGNATURE BELOW ONLY AT THE COMPLETION OF EXAM.

I did not leave any personal belongings upon completion of exam. _____