



CT WORKSHEET

PATIENT INFORMATION

Name: _____ Date: _____ Age: _____ Wt: _____ Sex: _____

REASON FOR EXAM: _____

MEDICAL HISTORY:

Yes No

- High Blood Pressure
- Asthma
- Multiple Myeloma
- Heart Disease
- Kidney Problems
- Dialysis Next Date: _____
- Collagen Vascular Disease (ie: Lupus)
- Diabetes

If yes, please circle any medication you are taking:
Metformin, Glucophage, Fortamet, Glucovance,
Glucophage XR, Glumetza, Riomet, ActoPlus Met,
Avandemet, Janumet, Pradimet and Hydroxyurea

SURGICAL HISTORY: _____

CANCER HISTORY: Yes No

If yes, what type(s) _____

PRIOR STUDIES: _____

ALLERGIES:

- Any Known Drug Allergies
- Iodine/ X-ray Dye
- Severe reaction to other medicine or food

Patient Signature: _____

(Technologist use only)

PATIENT MRN: _____

PROTOCOL: _____ RADIOLOGIST: _____

Exam: _____ Ordering Physician & Phone#: _____

Hospitals Use Only: Patient Location: ER Outpatient Inpatient-Room# _____

CONTRAST:

IV Optiray350 Optiray320 Omnipaque350 Isovue300 Isovue370 Visipaque320
(for Cardiac CTA Only)

Dose _____ cc Rate: _____ cc/sec Delay: _____ sec Lot#: _____ Exp Date: _____

IV Site: RIGHT LEFT Circle one: Hand Wrist Antecubital Power PICC/Port

CONTRAST REACTION: Yes No Explanation: _____

ORAL: _____ RECTAL: _____

LABS:

Creatinine: _____ mg/dl (0.6-1.3mg/dl) Lab or I-Stat GFR: _____
(Circle one)

hCG: _____ D-Dimer: _____ Date: _____

COMMENTS: _____

TECHNOLOGIST: _____

