Spectrum Radiology Associates, PLLC

1150 Youngs Road, Suite 111
Williamsville, NY 14221

Account # _____

IODINE ALLERGY ☐ Yes ☐ No

Please complete this form and bring it with you to your appointment.

CT

PATIENT NAME _____ AGE _____ SEX ____

PROCEDURE _____ DATE _____

REFERRING PHYSICIAN(S) _____ FOLLOW-UP DATE _____

A COPY OF THIS REPORT SHOULD BE SENT TO (**PHYSICIAN'S NAME**) _____

REASON FOR PROCEDURE/PATIENT SYMPTOMS

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

IF HISTORY OF CANCER: ANY SURGERY/BIOPSY? DATES _____

ANY CHEMOTHERAPY? DATES _____

ANY RADIATION THERAPY? DATES _____

PREVIOUS SURGERY

PART OF BODY	DATE PERFORMED	FACILITY/HOSPITAL

EXAMINATION HISTORY (WHAT/WHEN/WHERE)

X-RAYS _____

CT SCANS _____

MRI SCANS _____

ULTRASOUND _____

N.M. BONE SCANS _____

BONE DENSITY STUDY (DEXA) _____

COLONOSCOPY _____

UPPER ENDOSCOPY _____

UPPER GI _____

BARIUM ENEMA _____

BRONCHOSCOPY _____

MAMMOGRAPHY _____

CT PATIENT NAME _____ WEIGHT _____ AGE _____

TO BE VERIFIED BY PATIENT-HAVE YOU EVER HAD?

		YES	NO
1.	Any reaction to x-ray contrast or dye with the exception of a sensation of heat, flushing, or a single episode of nausea or vomiting?	☐	☐
2.	Any sensitivity to x-ray contrast or dye such as a single episode of nausea or vomiting?	☐	☐
3.	Seasonal allergies or any allergic reaction to any food or drug?	☐	☐
4.	Lung problems (emphysema, bronchitis, fluid in lungs, shortness of breath, pneumonia)?	☐	☐
5.	History of smoking? If yes: Number of years _____Packs per day _____Year quit _____	☐	☐
6.	Asthma?	☐	☐
7.	Diabetes? Insulin dependent or controlled by diet? Taking Glucophage ☐ Yes ☐ No If yes, was agent held?	☐	☐
8.	Multiple Myeloma?	☐	☐
9.	Pheochromocytoma?	☐	☐
10.	Seizures? Last one, how long ago? _____	☐	☐
11.	Kidney failure or dialysis? **Date** _____**GFR** _____ **BUN** _____**Creatinine** _____	☐	☐
12.	Heart or blood pressure problems (chest pain, irregular pulse, fainting spells, treatment for high blood pressure)?	☐	☐
13.	Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, or pulmonary hypertension?	☐	☐
14.	Generalized severe debilitation?	☐	☐
15.	Sickle cell anemia?	☐	☐
16.	Are you pregnant or nursing? Date of last menstrual period _____ If not sure, was pregnancy test done? Date _____ Results: Pos. or Neg. (circle)	☐	☐

_____ _____

Patient Signature Date

IV DOCUMENTATION Time _____

- ☐ Site _____
- ☐ Contrast _____
- ☐ Quantity _____ml
- ☐ IV rate _____ ml/sec
  - #20/#22 gauge (circle) angio-catheter
  - # _____ IV attempts
- ☐ Port previously accessed
- ☐ No reaction to contrast

COMMENTS: Injection followed by _____cc of normal saline.

_____

_____

Signature: _____

EXAM # _____

Pre-Authorization Obtained ☐ Yes ☐ No

Scan Instructions _____

_____

_____

_____

_____

_____

Technologist : _____