❑ STAT "Place X IN BOX IF STAT"

Name:_____ Sex: ☐Male ☐Female Date of Birth _____

Allergies:_____ Check if Allergy Pre-Medication Protocol Followed: ☐

_____ Date of Pre-Medication Protocol: _____

Height: _____ (ft or cm)_____(in) Weight: _____(lbs) (kg) Race: ☐Black ☐White ☐Hispanic ☐Asian ☐ Other

What symptoms brought you to the center? _____

Were you injured? ☐YES ☐ NO ☐ N/A How? _____ When? _____

PATIENT HISTORY

Have you experienced any of the following? (for Outpatients and Emergency Center patients only)

☐ Inpatient ☐ Outpatient ☐ ER Patient

YES	NO		YES	NO	
☐	☐	Renal (kidney) Disease * †	☐	☐	Proteinuria (protein in the urine) *
☐	☐	Renal (kidney) Surgery *	☐	☐	Hypertension (high blood pressure)*
☐	☐	Diabetes * †	☐	☐	Asthma †
☐	☐	Gout *	☐	☐	Congestive Heart Failure †
☐	☐	Multiple Myeloma * †	☐	☐	Glaucoma
☐	☐	Seizures	☐	☐	Sickle Cell disease †
☐	☐	Any serious allergic reactions to anything? †	☐	☐	History of Hepatitis
☐	☐	Liver transplant/pending liver transplant?*	☐	☐	History of Cancer Type:_____
☐	☐	Use of Metformin(Glucophage, Glucovance, etc.)*	☐	☐	Prior Surgery Type:_____
☐	☐	Have you received contrast media prior to this exam?			
☐	☐	If yes, did you have a reaction to the contrast agent? † Describe reaction: _____			
☐	☐	Are you currently on Dialysis? †			
☐	☐	Have you had a MRI with a contrast injection in the past 7 days?			

KEY: * = GFR calculation is required if yes
† = May authorize Visipaque if yes

Medication History *(for outpatients and Emergency Center patients only)*
Inpatient medication reviewed by Pharmacist ☐
Please provide information about each prescription medication, herbal supplement, over the counter (OTC) medication that you are currently taking.

DRUG NAME	DOSE STRENGTH/QUANTITY	ROUTE (ORAL,IV, ETC.)	HOW OFTEN	LAST DOSE DATE /TIME
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Patients with Diabetes

If you are taking Metformin (Glucophage, Glucovance, etc.) and having a contrast injection in X-ray or CT today, you will be asked to stop taking it for 48 hours post injection of contrast media. This does not apply to MRI contrast injections. Contact your primary physician prior to restarting your Metformin (Glucophage, Glucovance, etc.) to make sure your renal functions are okay.

I will stop my Metformin (Glucophage, Glucovance, etc.) and contact my physician before restarting it. _____ (Initial Here)

MEMORIAL HERMANN

Patient History/ Pre-IV Contrast Form

FEMALE PATIENTS

YES	NO		YES	NO	
☐	☐	Have you ever had a hysterectomy?	☐	☐	Any possibility that you are pregnant?
☐	☐	Were your ovaries removed?			Date of last menstrual period? _____
☐	☐	Do you have an IUD?			Total pregnancies: _____
☐	☐	Do you use birth control pills?			Miscarriages: _____
☐	☐	Tubal Ligation			
☐	☐	Do you have a positive pregnancy test now?			
		If yes, by: ☐ Blood ☐Urine			
		If yes, when did you test positive: _____			

OFFICE USE ONLY

Contrast Media Requested: Check Dose

❑50ml ❑100ml ❑150ml Omnipaque
❑50ml ❑100ml ❑150ml Visipaque
❑10ml ❑20ml ❑50ml ❑100ml Normal Saline
Lot #: _____ Other Dose: _____ml

Route of administration is IV: Frequency is once

❑_____ml Omniscan (Gadolinium Other dose _____ml)
❑_____ml Magnevist Lot# _____

Pregnancy Test Results: ❑ Positive ❑ Negative (Reference range; Negative) Date/Time Collection: _____
iStat used ❑ YES ❑ NO
Creatinine: _____0.5 - 1.4 mg/dl Date/Time Collection:_____ Estimated GFR: _____ml/min/1.73m^2
Glucose: _____70 - 99 mg/dl Date/Time Collection:_____

Is the patient taking Metformin or Metformin containing drugs ☐ Yes ☐ No

Name of Radiologist who approved giving contrast if applicable: Dr._____
30 or Below for CT / X-Ray and 60 or below for MRI

Name of Nephrologist who approved giving contrast if applicable: Dr._____
30 or Below for MRI

Patient is being hydrated before and after administration of contrast. Yes_____MD initial (For CT/X-Ray below 30)

Physician Signature: _____ Print Name: _____ Date/Time: _____

Pharmacist Approval: ❑ Yes ❑ No

Pharmacy Review – in down time, fax to _____ Follow up with a call to_____

Pharmacy Signature: _____ Print Name: _____ Date/Time:_____

FAX BACK TO

MRI	CT	X-ray	OPID CT
X_____	X_____	X_____	X_____
Dept. Phone:			
X_____	X_____	X_____	X_____

Technologist Comments:

❑Yes ❑No Is this patient a suspected victim of abuse? ❑Yes ❑No Is this patient a fall risk?

❑Yes ❑No Patient tolerated exam ❑Yes ❑No Patient discharged without complaint

COMMENTS:_____

_____

Technologist / Nurse Signature: Print Name: Date/Time:

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Patient History/ Pre-IV Contrast Form