MASSACHUSETTS GENERAL HOSPITAL
IMAGING

Computed Tomography (CT)
Patient Procedure Screening Form

Date: _____/_____/_____ (MRN): ________________________ Date of Birth: _____/_____/_____ Male Female

Name: ____ Weight: ______Height________
Last Name First Name Middle Initial

Body part to be examined: ____If applicable, which side? ☐ Right ☐ Left

Yes No Have you had anything to eat in the last 2 hours?
Yes No Do you have another appointment after this exam today? If yes, where? ________________________
Yes No Have you had a Barium study within the past two weeks?
Yes No Are you on, or have ever received Interleukin-2 therapy in the last 2 years?
Yes No Do you have a PowerPort, Central Access or IV access?
Yes No Have you had labs drawn recently? If yes, where? ____
Yes No Any history of surgery? Please list: ____
Yes No Are you currently on Dialysis? Hemodialysis or Peritoneal Dialysis?
Yes No Have you ever had IV Contrast (also known as x-ray dye) injection?
Yes No Have you ever had an allergy or reaction to IV contrast? If yes, please explain:

Rash, Hives ☐ **Nausea, Vomiting** ☐ **Swelling; eyes, face** ☐ **Shortness of Breath** ☐ **Other**

____

Yes No Have you ever had an allergy to Oral Contrast?
Yes No Do you have any known allergies to medication, food, or seasonal, etc.)? Please list below:

____

Yes No Have you been pre-medicated for today's study?

Do you have any of the following conditions or take any of the following medications?:

Yes	No	**Asthma**	Yes	No	**Kidney Disease (including partial or single kidney)**
Yes	No	**Diabetes**	Yes	No	**Congestive Heart Failure (CHF)**
Yes	No	**Metformin**	Yes	No	**Collagen Vascular Disease: e.g. Lupus**
Yes	No	**Multiple Myeloma**	Yes	No	**Severe Anemia**
Yes	No	**Thyroid Disease**	Yes	No	**Glaucoma**
Yes	No	**Sickle Cell Anemia**	Yes	No	**Hypertrophic Obstructive Cardiomyopathy**
Yes	No	**Pheochromocytoma**	Yes	No	**Critical Aortic Stenosis**
Yes	No	**Hydroxurea**	Yes	No	**Intracranial Hemorrhage**
Yes	No	**History of Cancer**	Yes	No	**Erectile Dysfunction Medications** (i.e. Levitra, Adcirca, Cialis, Revatio or Viagra)

Females only: Is there a reasonable possibility that you may be pregnant? Yes No
Are you breast feeding? Yes No

Patient's signature
(or attendant): ____ Date____________________________

RT/RN Signature: ____

Staff use only: **GOOD to GO FORM** ***(technologists please initial)***

Actively verify Patient ID/DOB with ID band & exam form: _______ _______
Confirm correct exam (body part, position, protocol) _______ _______
Confirm the correct is protocol selected in the scanner: ______________

☐ WO -Contrast

Contrast verification

Patient allergies: _______ _______
eGFR reviewed: _______ _______
Contraindications: _________ _________
Power Injector prepared by: ___________

RT signature: ______________________________ **RT signature:** ______________________________