DEPARTMENT OF RADIOLOGY
Dartmouth-Hitchcock
MEDICAL CENTER

CT Safety and Scheduling Questionnaire

MRN:

NAME:

DOB:

two identifiers needed
or
patient label

Date: ________________________ Patient's Weight: ________________________ Patient's Age: __________________

Have you ever had renal/ kidney problems or kidney surgery?*	Yes	No
Do you have or are you being treated for high blood pressure, diabetes or gout?*	Yes	No
Have you ever had a prior reaction to the injection of CT or X-ray IV contrast dye? If YES, please describe type of reaction:______________________________	Yes	No
Have you been diagnosed with, or are you being treated for multiple myeloma?	Yes	No
Are you pregnant? (females between 8 and 56 years)	Yes	No

*For YES answer to these questions, a creatinine within 45 days of the scheduled exam is needed.

Most recent creatinine on file:______________________________

Date of creatinine:

____

Does the patient require sedation?
____Yes ____No

Does the patient need the bicarb protocol or other hydration protocol? ____Yes ____No

What type of oral prep will they be given?

____

Do you have a mediport?	Yes	No
Do you have difficulty breathing or pain while lying flat?	Yes	No
Do you have any mobility concerns? If YES, please describe:__________________________	Yes	No
Do you ambulate (walk) without assistance?	Yes	No
Are you coming from a skilled care facility? **If yes, you must be accompanied by a caregiver for the entire exam/ transportation arrangements must be made in advance.**	Yes	No

Form Completed By: ____ Date: ___________________________