Dartmouth Health

CT Safety and Scheduling Questionnaire

MRN:

NAME:

two identifiers needed
or
patient label

DOB:

Date: _____Patient's Weight (lbs.): _____Patient's Height (ft/in): _____

Have you ever been told you have renal/kidney problems?	Yes	No
Have you ever been told you have protein in your urine?	Yes	No
Do you have high blood pressure?	Yes	No
Do you have diabetes mellitus?		
Do you have gout?	Yes	No
Have you ever had kidney surgery?	Yes	No

For any YES answer to questions 1 through 6 the patient will need an eGFR within 30 days of the scheduled exam.

Most recent eGFR on file: _____ Date of eGFR: _____ If no eGFR one will be ordered: _____

Have you ever had a prior reaction to the injection of CT or x-ray IV contrast dye?	Yes	No
Do you use a glucose monitoring system or an insulin pump?	Yes	No
Are you scheduled to have a barium swallow study within 5 days prior to your scheduled CT exam? (The CT exam needs to be 5 days after any barium study)	Yes	No
Do you have a Mediport or other active implanted port that they would like to use? (Ability to use their Mediport is site dependent)		
Can you walk without assistance, including walking without a cane/walker? If no, list in comments what assistive device is needed.	Yes	No
Are you coming from a Skilled Care Facility? (If yes, patient must come with caregiver)	Yes	No

If the patient has had a prior reaction to the injection of IV contrast dye:

For mild reactions please prescribe 3 predniSONE (Deltasone) 50 mg tablets to be taken: one tablet by mouth at least 13 hours, 7 hours and 1 hour prior to scheduled exam.

For severe/anaphylactoid (laryngeal edema, hypotension, bronchospasm, respiratory distress) use of IV contrast is contraindicated. Please order a non-contrast study or another imaging exam.

Form Completed By: _____Date: _____