AFFIX PATIENT INFO LABEL HERE

Patient Name ____________________ MR# __________

HACKENSACK UNIVERSITY MEDICAL CENTER

INTRAVENOUS CONTRAST QUESTIONNAIRE

Directions:
- **Request patient or family member to complete the questionnaire below.**
- **Attach this questionnaire to CT scan request and send to Dept. of Radiology.**

1. Have you ever had an x-ray study before which involved injection of a contrast agent or x-ray dye? ☐ **Yes** ☐ **No**
   If yes, did you have any reaction to this injection? ☐ **Yes** ☐ **No**
   If yes, please describe this reaction: ____________________

2. Are you allergic to any foods, medicine or other substances? ☐ **Yes** ☐ **No**
   If yes, please describe:
   ____
   What happens when you have this allergy? ***(For example, do you get hives, etc.)***
   ____

3. Do you have asthma? ☐ **Yes** ☐ **No**
   Do you take medicine for it? ☐ **Yes** ☐ **No**
   If so, which ones? ____________________
   Have you ever been hospitalized for asthma? ☐ **Yes** ☐ **No**

4. Are you diabetic? ☐ **Yes** ☐ **No**
   Do you take ***Glucophage/Glucovance/Avandament/Metaglip***? ☐ **Yes** ☐ **No**
   Do you take Insulin? ☐ **Yes** ☐ **No**

5. Are you currently/recently undergoing treatment with ***interleukin***? ☐ **Yes** ☐ **No**

6. Do you take beta-blockers? ***(e.g., Inderal, Tenormin, Lopressor)*** ☐ **Yes** ☐ **No**

7. Do you have:
   - **Kidney problems**? ☐ **Yes** ☐ **No**
   - **Heart problems**? ☐ **Yes** ☐ **No**
   - **Multiple Myeloma**? ☐ **Yes** ☐ **No**
   - **Sickle Cell Anemia**? ☐ **Yes** ☐ **No**
   - **Thyroid Disease**? ☐ **Yes** ☐ **No**
   - **Pheochromocytoma** *(adrenal tumor)*? ☐ **Yes** ☐ **No**
   - ***Other major disease***? ☐ **Yes** ☐ **No**

   If so, which ones? ____________________

8. Are you pregnant? ☐ **Yes** ☐ **No**

9. Is there anything else which you think we should know about you or your health?
   ____

____
Name of person completing form

HackensackUMC

HACKENSACK UNIVERSITY MEDICAL CENTER

DEPARTMENT OF RADIOLOGY

AFFIX PATIENT INFO LABEL HERE

Patient Name ____________________ MR# __________

I. INTRODUCTION

Your doctor has scheduled you for an x-ray examination that requires injecting contrast media into a vein. This helps visualize certain organs and blood vessels.

II. POSSIBLE REACTIONS

All medical procedures carry an element of risk and this procedure is no exception. It is our intention. To describe these risks and then request your signature indicating your understanding of this information.

Minor allergic reactions to intravenous contrast *(Iodine)* occur in about two to ten percent of patients receiving contrast. Fortunately, most reactions are minor *(warmth, nausea, vomiting, minor hives, or itching)* and no treatment is required. Serious complications occur in about one in two thousand examinations and include *serious allergic reactions, fall in blood pressure, shock , shortness of breath, convulsions, and renal failure.* The risk of a serious complication is increased two or four times if you are diabetic or have a history of asthma or other allergies, or have had a previous reaction to contrast *(Iodine).* The risk for serious allergic reaction to iodinated contrast usually lasts for only 5-10 minutes after the injection. Rarely *(reports vary from 1 in 10,000 to 1 in 75,000)*, these serious complications may result in death.

Your doctor has considered these risks before recommending this examination and believes that the diagnostic benefits far outweigh the minimal risk involved.

I understand this information ☐ **Yes** ☐ **No**

____

(Signature of Patient or Guardian)

Patient information reviewd by: ______________________________

(Signature)

Injected by: ____

I would like to discuss this procedure with a physician ☐ **Yes** ☐ **No**

If yes, physician information given by: ______________________________

(Signature)