BOCA RATON
REGIONAL HOSPITAL

RADIOLOGY CONTRAST EVALUATION

Procedure: _____ Creatinine: _____

Do you have any history of Allergies (medication or foods) or Asthma? ☐ Yes ☐ No

V07.1	Desensitization to Allergies	V15.0	Allergy to non medications	995.1	Angioneurotic Edema	995.0	Anaphylactic Shock
V14.8	Previous adverse reaction to Contrast ☐ Y ☐ N	V14.0	Penicillin	V14.1	Other Antibiotic Agents	V14.2	Sulfonamides
	When? _____	V14.3	Other anti-infective agents	V14.4	Anesthetic Agents	V14.5	Narcotic Agents
	Describe: _____	V14.7	Serum or Vaccines	V14.8	Other Medications	V14.9	Unspecified Medications
	_____	493.90	History of Asthma	495.9	Unspecified Allergic Alveolitis/pneumonia	995.3	Non-specified Allergy
		995.2	Adverse drug effect			Other:	_____
V14.6	Analgesic agents		Medicinal or Biological		Lung Diseases, Chronic		_____

Comments: _____

Do you have any history of Heart Conditions? ☐ Yes ☐ No

416.0	Pulmonary Hypertension	402.90	Hypertensive Heart Disease	411.1	Intermediate Coronary Syndrome (Angina)	427.41	Ventricular Fibrillation
428.0	Congestive Heart Failure	427.31	Atrial Fibrillation			Other:	_____
427.9	Arrythmias	427.60	Premature Beats, Unspecified	429.2	Cardiovascular Disease, Unspecified		_____
429.9	Heart Disease, Unspecified						_____

Comments: _____

Do you have any history of Chronic or Debilitating Conditions? ☐ Yes ☐ No

203.00	Multiple Myeloma without mention of remission	203.01	Multiple Myeloma in remission	250.00	Diabetes mellitus without mention of complication	282.61	Hb-S without mention of Crisis
799.3	Unspecified Debilitation	518.81	Respiratory Failure	250.93	Diabetes mellitus with Ketoacidosis	V42.0	Post-Renal Transplant
	Describe: _____	282.63	Sickle Cell/Hb-C Disease			Other:	_____
282.60	Sickle Cell Anemia, Unspecified	586	Renal Failure, unspecified	V46.1	Dependence on respirator		_____
		585	Renal Failure, chronic	799.4	Wasting (Cachexia)		_____

Do you take Glucophage, Glucophage XR, Glucovance, Avandamet, Metaglip, Riomet, Altimetformin, Metformin, Glumetz R Apometformin, Genmetformin, Glycon, Novometformin, Numetformin, Pmsmetformin, Rhometformin, Rhoxalmetformin, Fortamet? ☐ Yes ☐ No

ORDER HISTORY:

Have you ever been diagnosed with cancer? ☐ Y ☐ N If yes, describe: _____
If yes, have you had radiation or chemotherapy? ☐ Y ☐ N When did you finish treatments? _____

Have you had any previous surgery in the area that you are having scanned today? ☐ Y ☐ N If yes, when? _____
Describe your surgeries: _____
_____

Have you had any previous diagnostic exams for same area that you are having scanned today? ☐ Y ☐ N
Describe (MRI, CT Scan, Nuclear Medicine, X-Rays, Ultrasound, Lab Work): _____
_____

Why are you having this exam today? _____
_____

Female Patients: Is there any possibility that you may be pregnant or nursing? ☐ Y ☐ N Date of Last Menstrual Period: _____

Explanation about the nature of my procedure has been discussed with me. My questions have been answered and I consent to receive the contrast agent.

Signature of Patient/Guardian: _____ Date: _____

Complications: ☐ Y ☐ N If yes, describe: _____

Type/amount contrast administered: _____ IV Location _____

Signature of Technologist: _____

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