

Patient Contrast Screening Tool

Patient Name: _____ MR #: _____

Date: _____ DOB: _____

Study: _____ Type of Contrast: _____

Route of Administration: _____ Type of Administration: _____

Dose Amount: _____ Administered By: _____

Patient's Current Medications:

Medication Name	Dosage	Frequency	Route

Allergies including previous contrast reactions: _____

Is patient pregnant? Y N

Barium Sulfate:

1. Have you ever had previous reactions to barium? Y N

If yes, indicate type of reaction: _____

Gadolinium:

1. Have you ever had previous reactions to gadolinium? Y N

If yes, indicate type of reaction: _____

Iodinated Contrast

1. Hx of renal disease? Y N

2. Hx of multiple myeloma? Y N

3. Is patient diabetic? Y N

If yes – Is patient taking metformin? Y N

4. Hx of CHF? Y N

Complications from today's contrast administration? Y N

If yes, indicate action taken: _____

PLEASE FAX THE COMPLETED FORM TO PHARMACY AT XXX-XXXX AND RADIOLOGY AT XXX-XXX.



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