

CT Contrast Subject Screening Questionnaire

Please complete the survey below.

Thank you!

THE MOUNT SINAI HEALTH SYSTEM

BIOMEDICAL ENGINEERING AND IMAGING INSTITUTE

INTRAVENOUS IODINATED CONTRAST INFORMATION & QUESTIONNAIRE

Date of Imaging Appointment: [appointment_date_intro]

Subject Name: [subject_lastname_intro], [subject_firstname_intro]

Birthdate: [subject_dob_intro]

Insurance Gender (Gender selected under insurance): [insurance_gender_intro]

Gender Preferred Pronoun: [gender_identity_intro]

Study Principal Investigator: [pi_name]

Study Coordinator/Nurse: [study_coordinator]

Medical Record Number (MRN): [mrn_intro]

PLEASE READ THE FOLLOWING INFORMATION REGARDING CONTRASTS

Your doctor has ordered a CT scan or X-ray examination which requires you to have contrast material (dye) injected into your blood vessels to see certain parts of your body better during the procedure. This will allow the radiologist to make a more complete interpretation of your test.

Contrast material is a clear fluid that contains iodine. It is injected at a carefully controlled rate by a computerized injector. Upon injection some patients feel warmth through their body or sense a metallic taste in their mouth; both of these resolve quickly. Nausea with or without vomiting can also occur. Certain patients may require a blood test to determine kidney function before receiving contrast. Uncommon complications of contrast material injection include a temporary allergic-type reaction characterized by itching and hives, or sneezing and swelling of the eyes and lips. You may receive Benadryl, an antihistamine, if the radiologist believes your reaction warrants treatment. Another uncommon event is leakage of contrast material out of the vein and into tissues near the injection site. This may cause localized pain and injury. The radiologist or nurse may elevate the affected arm and place cold compress about the injection site to help the swelling decline more rapidly. Very rare complications include, but are not limited to, shock, kidney failure, difficulty breathing, seizures, cardiac arrest and death. We are prepared to treat such a reaction if it occurs, but in some instances we obtain assistance from hospital emergency care team. Please note that even though your study may have been ordered by your doctor with contrast, the injection may be withheld in some situations, such as an abnormal laboratory result or potential medication reaction.

1. Do you have any of the following:

- ☐ Age > 60
- ☐ Single Kidney
- ☐ Kidney transplant
- ☐ Kidney cancer
- ☐ History of kidney surgery
- ☐ Other kidney disease (chronic kidney disease, on dialysis, etc)
- ☐ High blood pressure or taking medication to keep your blood pressure controlled
- ☐ Diabetes or taking medication to control your blood sugar
- ☐ Taking metformin
- ☐ Iodinated contrast allergy (for example contrast for CT or angiogram)
- ☐ Latex allergy
- ☐ NONE OF THE ABOVE

1a. If you had a reaction, please describe:

2. Have you ever been pre-medicated before a contrast injection, such as with Benadryl (diphenhydramine), other antihistamines or steroids?

☐ Yes ☐ No ☐ Unknown

2a. If YES, please describe:

FOR FEMALES (12 YEARS AND OLDER AND/OR MENSES IN 12 MONTHS, AND OF CHILD BEARING POTENTIAL)

3. Is there any possibility that you might be pregnant? [patient_female_intro]

4. Date of last menstruation:

If you are pregnant or may be pregnant, certain CT scans and X-ray procedures could theoretically cause harm to your unborn child.

5. Do you wish to discuss contrast further with a Radiology nurse or physician?

☐ Yes ☐ No

When your question(s) about contrast have been answered, and you have completed the questionnaire please acknowledge below:

"I have completely read and provided the information required on this form. I fully understand its contents, including possible risks and complications. I have been given an opportunity to ask questions. All of my questions have been answered fully and satisfactorily".

Did you require assistance in completing this questionnaire? [need_help_intro]

FOR SUBJECTS REQUIRING ASSISTANCE TO COMPLETE THIS QUESTIONNAIRE

Name of Individual completing this questionnaire: [lastname_intro], [firstname_intro]

Relationship to patient: [relationship_to_subject_intro]

Date questionnaire is completed: [form_date]

Time questionnaire is completed: [completing_time_intro]

PLEASE MAKE SURE TO REVIEW ALL QUESTIONS AND ANSWERS BEFORE SUBMITTING

FOR INTERNAL USE ONLY

If RN or MD is assisting the patient, will information to complete this questionnaire be corroborated by chart history? [corroborated_intro]

Contrast Policy

Age > 60	Check creatinine
Single Kidney	Check creatinine
Kidney transplant	Check creatinine
Kidney cancer	Check creatinine
History of kidney surgery	Check creatinine
Other Kidney disease	Check creatinine
High blood pressure	Check creatinine
Diabetes	Check creatinine
Taking metformin	Check creatinine
Allergy to contrast	Assess details
Iodinated contrast allergy (for example contrast for CT or angiogram)	Assess details
Latex allergy	Use latex free gloves
For women only: Any chance of pregnancy?	Assess details. Is a pregnancy test needed?

Verify with the patient whether they have had anything to eat or drink in the last two (2) hours?

Current weight: [subject_weight_intro] [weight_measurement_intro]

Name of CT Tech Reviewing CT subject Screening
Questionnaire Responses: _____

Name of Registered Nurse (RN) Reviewing CT subject
Screening Questionnaire Responses: _____

RENAL FUNCTION TESTING

DRAWN: _____

CHECKED: ☐ Yes ☐ No

CHECKED BY:
(Initials)

VALUES
eGFR (mL/min/1.73m²):

eGFR Results:

- ☐ African American (AA)
☐ non-African American (non-AA)

VALUES
Creatinine (Cr):
(mg/dL)

INJECTION DETAILS

CT CONTRAST AGENT AND CONCENTRATION:

INJECTION SITE:

CONTRAST VOLUME (mL):

CONTRAST RATE (mL/s):

OUTCOME:
(See electronic / supplementary documentation for details)

- ☐ Routine injection ☐ Contrast Reaction
☐ Extravasation ☐ Other Event

Injecting / Nursing Personnel TITLE:

Injecting / Nursing Personnel SIGNATURE:

FOR INTERNAL USE ONLY
Tech/ RN Verification

Question 1. Do you have any of the following:

(Tech comment on how this was resolved)

Was answered with selection (s)

0, Age > 60
1, Single Kidney
2, Kidney transplant
3, Kidney cancer
4, History of kidney surgery
5, Other kidney disease (chronic kidney disease, on dialysis, etc)
6, High blood pressure or taking medication to keep your blood pressure controlled
7, Diabetes or taking medication to control your blood sugar
8, Taking metformin
9, Iodinated contrast allergy (for example contrast for CT or angiogram)
10, Latex allergy
99, NONE OF THE ABOVE

Question If you had a reaction, please describe:

Was answered

(Tech comment on how this was resolved)

Question 2. Have you ever been pre-medicated before a contrast injection, such as with Benadryl (diphenhydramine), other antihistamines or steroids?

(Tech comment on how this was resolved)

Was answered "YES"

Question 3. Do you have a history of severe allergies or active asthma?

Was answered "YES"

(Tech comment on how this was resolved)

Question 10. Have you had anything to eat or drink in the last two (2) hours?

Was answered "YES"

(Tech comment on how this was resolved)