Houston MRI & Diagnostic Imaging

Facility:	Referring:
MRN:	Radiologist:
DOS:	Delivery:

CT CONSENT FORM

CONSENT FOR CT EXAMINATIONS

Patient: _____ Minor ○Yes ○No

Referring Doctor:_____

Examination to be performed:

_____

When is your next follow up appointment with your doctor?

_____

I consent to these diagnostic x-ray procedure(s) my referring doctor may consider necessary or advisable in the course of my health care. I understand that the above listed diagnostic x-ray procedure(s) have been ordered by my referring doctor and are to be performed at Houston MRI by or under the supervision of a radiologist and/or radiological technologist. I understand the nature and purposes of these procedure(s) and the risks involved, and the possible consequences of not consenting to the procedure(s).

_____ Date: _____/_____/_____
Patient / Guardian Signature

_____ _____
Witness Relationship

FEMALE PATIENTS ONLY

Some X-Ray and CT examinations may expose the uterus. In order to avoid unnecessary fetal exposure in the event of a pregnancy, the 10 days immediately following onset of menstrual period are generally considered safest for x-ray/CT examinations.

Onset of last menstrual period. Date: ____/____/____ Today's Date: ____/____/_____

I am postmenopausal	○Yes	○No	○Don't know
I am pregnant	○Yes	○No	○Don't know
I have had a hysterectomy	○Yes	○No	○Don't know
I use an IUD	○Yes	○No	○Don't know

I recognize that if I am pregnant and have radiation, there is a possibility of injury to the fetus. However, I understand that the likelihood of such injury is slight and that my physician feels that the information to be gained from this examination is important to my health. I therefore wish to have this x-ray/CT examination performed now.

_____ Date: _____/_____/_____
Patient / Guardian Signature

_____ _____
Witness Relationship

Houston MRI & Diagnostic Imaging

Facility:	Referring:
MRN:	Radiologist:
DOS:	Delivery:

CT PATIENT HISTORY

Patient name: _____

Date: _____ Type of exam: _____

Weight: _____ Height: _____ *(Female patients)*: Are you pregnant, or suspect you may be pregnant ○Yes ○No

When is your next follow up appointment with your doctor? _____

Explain present condition (How and When you were injured? Where is your pain, and for how long?):

_____

_____

Do you have or have you had any of the following:

Adrenal Cancer	○Yes ○No	Gout	○Yes ○No	Peripheral Vascular Disease	○Yes ○No
AIDS or HIV	○Yes ○No	Heart Disease	○Yes ○No	Previous Head Injury/Bleed	○Yes ○No
Asbestos Exposure	○Yes ○No	Hypertension	○Yes ○No	Proteinuria (Protein in Urine)	○Yes ○No
Asthma	○Yes ○No	Kidney Disease	○Yes ○No	Radiation Therapy	○Yes ○No
Cancer	○Yes ○No	Liver Disease	○Yes ○No	Rheumatoid Arthritis/Scleroderma	○Yes ○No
Chemotherapy	○Yes ○No	Lupus	○Yes ○No	Sickle Cell Disease	○Yes ○No
Diabetes	○Yes ○No	Myeloma	○Yes ○No	Stroke	○Yes ○No

Please list any other medical conditions not listed above:

_____

Have you ever had surgery? ❑Yes ❑No

List any and all past surgeries and the year they were done:

_____

_____

Have you had any previous imaging studies related to today's procedure? ○Yes ○No

If yes, please list type of study, date and location:

_____

Have you been diagnosed with diabetes? ○Yes ○No

If yes, do you take any medications containing metformin such as Glucophage, Glucovance, Avandamet, Janumet, or Metaglip? ○Yes ○No

If you are taking any of the medications listed above, it must be withheld for 48 hours following the exam. Did your Doctor instruct you to do this? ○Yes ○No

Do you have any allergies? ○Yes ○No If yes, please list:_____

Are you allergic to the following? Iodine ○Yes ○No X-Ray Dye ○Yes ○No Seafood ○Yes ○No

Have you had intra-venous iodine injected into a vein? ○Yes ○No If yes, please check if you had:

Anaphylactic Shock	○Yes ○No	Nausea	○Yes ○No	Vomiting	○Yes ○No
Hives/Red bumps	○Yes ○No	Redness of Skin	○Yes ○No	Other	○Yes ○No
Loss of Consciousness	○Yes ○No	Shortness of Breath	○Yes ○No		

_____

Appointment Confirmed by: _____ Date: _____

TECHNOLOGIST SECTION

Contrast type: _____ Amount injected: _____ Amount wasted: _____

Exp Date: _____ Lot: _____ # of IV attempts: _____

Infiltration ○Yes ○No Injection site: _____ Injection time: _____

Inj supervision verified? ○Yes ○No Consent form signed? ○Yes ○No Post-proc instructions given? ○Yes ○No

Completed by: _____ Date: _____ Time: _____