Scheduled Exam Time _____ Ready _____

UVA Imaging

Outpatient Diagnostic Imaging Centers

Patient Name:

MR #

Addressograph

CONTRAST (DYE) SCREENING FORM

Before beginning your study, it is necessary that you answer the following questions:

		COMMENTS / DESCRIBE:	
Have you ever had contrast material (dye) for a kidney x-ray, CT, MRI, or other imaging test/study?	☐YES ☐NO		
If yes, did you have any discomfort, ill effects, or allergic reaction? *If Yes, Describe:*	☐YES ☐NO		
Do you have asthma or severe allergies? *If Yes, Describe:*	☐YES ☐NO		
Do you have a Vascular Access Port, PICC line or catheter? *If Yes, Describe:*	☐YES ☐NO		
Do you have diabetes?	☐YES ☐NO		
Do you take generic metformin (Glucophage, Avandamet, Glucovance, Metaglip)?	☐YES ☐NO		
Do you have heart or vascular disease? *If Yes, Describe:*	☐YES ☐NO	Do you now have or have you had kidney disease or any history of kidney problems? *If Yes, Describe:*	☐YES ☐NO
Do you have sickle cell anemia?	☐YES ☐NO	Do you have a seizure disorder?	☐YES ☐NO
Do you have Multiple Myeloma?	☐YES ☐NO	Is there any chance that you are pregnant, or are you breastfeeding?	☐YES ☐NO

Patient Signature: _____ Date: _____

TECHNOLOGIST OR NURSE USE ONLY

DATE: _____ TIME: _____ PROCEDURE: _____

VENIPUNCTURE SITE: _____ TYPE NEEDLE/CATH: _____ # STICKS: _____

PERFORMED BY: _____ RADIOLOGIST: _____

CONTRAST TYPE/AMT.: _____ INJECTED BY: _____

INJECTION RATE: _____ I.V. DISCONTINUED BY: _____

CONTRAST LOT #: _____ PATIENT/FAMILY EDUCATION: YES NO _____

Creatinine: _____ Date: _____ Source: _____ Weight: _____ Creatinine Clearance _____

OUTPATIENTS: ☐NOTIFICATION REGARDING METFORMIN & IV CONTRAST FAXED TO ORDERING PHYSICIAN

☐PATIENT GIVEN COPY OF NOTIFICATION

Technologist / Nurse Signature: _____

Please call (434) 924-9400 and ask for the Radiology Resident on Call if you have any concerns.