



0500004

PLACE LABEL HERE.
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

IV CONTRAST (DYE) SCREENING FORM

PERTINENT LAB VALUES: BUN _____ CREATININE _____ Creatinine Clearance\ GFR: _____

No Labs Available **SOURCE:** _____ **DATE:** _____ (labs must be within 90 days of the exam)

Radiologist protocol for this exam: _____

Radiologist: _____ **PIC** _____
(SIGNATURE)

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? YES NO

Do you take generic metformin (Glucophage, Avandamet, Glucovance, or Metaglip)? YES NO

Is there any chance that you may be pregnant? YES NO **LMP:** _____

Do you have heart disease or vascular disease? YES NO **Are you breast feeding?** YES NO

Do you have asthma? YES NO **Do you have diabetes?** YES NO

Are you allergic to anything? YES NO **Do you have sickle cell anemia?** YES NO

Have you had a history of kidney disease? YES NO **Do you have multiple myeloma?** YES NO

Comments: _____

Information obtained from: Patient Medical Record Family

Information obtained by: _____ **Date:** _____

No changes required:

Exceptions reviewed and protocol changed to: _____

Radiologist revising protocol: _____ **PIC** _____
(SIGNATURE)

VENIPUNCTURE INFORMATION Pre-existing IV **Flushed by:** _____

DATE: _____ **TIME:** _____ **VENIPUNCTURE SITE:** _____ **# STICKS:** _____

TYPE NEEDLE/CATH: _____ **PERFORMED BY:** _____ **INJECT RATE:** _____

CONTRAST TYPE: _____ **CONTRAST AMOUNT:** _____ **LOT #:** _____

INJECTED BY: _____ **IV DISCONTINUED BY:** _____

PATIENT / FAMILY EDUCATION: YES / NO _____

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

PATIENT GIVEN A COPY OF NOTIFICATION REGARDING METFORMIN INFORMATION

INPATIENTS: NOTE REGARDING METFORMIN INFORMATION PLACED IN PATIENTS MEDICAL RECORD

Technologist / Nurse Signature: _____ **Date:** _____