CT SCREENING FORM

Patient Name: ______________________________

Date of Birth: ______________________________

Male Female Weight: __________ Height: __________

ARE YOU DIABETIC OR HAVE RENAL DISEASE? YES NO

CLAUSTROPHOBIC: YES NO

What symptoms are you experiencing? ______________________________

Referring Physician: ______________________________

PLEASE CHECK BELOW ALL OF THE MEDICAL CONDITIONS THAT APPLY TO YOU:

YES	NO	Have you ever had IV contrast (dye) injection in the past? (Cardiac Cath, CT, MRI, Other)
YES	NO	Are you allergic to iodine or iodine containing substance? ______
YES	NO	Do you have both kidneys? ______
YES	NO	Do you have asthma or lung disease? ______
YES	NO	Have you been diagnosed with epilepsy or seizure disorder? ______
YES	NO	Do you have high blood pressure (hypertension)? ______
YES	NO	Do you have heart disease? ______
YES	NO	Do you have a history of cancer; if yes, explain: ______
YES	NO	Do you have a history of stroke? ______

FEMALE PATIENTS

YES	NO	Is there a chance that you are pregnant?
YES	NO	Are you currently pregnant?
YES	NO	Have you had a hysterectomy or tubal ligation?
YES	NO	Are you currently nursing?

FORM OF BIRTH CONTROL

Abstinence	Condom
Birth Control Pill/Patch	IUD
Diaphragm	Menopause
Vasectomy	None

Patient Signature: ______________________ **Date:** ______________

CONTRAST PATIENTS ONLY

Your physician has requested that we perform a diagnostic imaging exam to obtain additional information. As part of your exam, a contrast agent may be injected into your vein in order to produce better images of the indicated area. Potential risk include; pain, bleeding, bruising, swelling, mild headache, nausea, itching or other vague symptoms for a short time after the injection. Additional allergic reactions in response to the contrast agent may include: hives, shortness of breath, or difficulty swallowing. **It is very important that you inform the technologist if you experience any of the conditions mentioned on this form.**

NOTE TO PATIENTS: Please inform the technologist if any of the following apply to you: Previous reaction to contrast injection such as hives, severe itching, shortness of breath and/or any significant reaction requiring hospitalization, a history of asthma or other allergic conditions, any history of kidney disorders, Sickle Cell Anemia for MRI exams, and if you are pregnant or breast feeding. Please inform the technologist if you are taking a form of Metformin medication for CT exams.

______________________________ ______________________
Patient | Guardian Signature **Date:**

______________________________ ______________________
Technologist Signature **Date:**

INTERNAL USE ONLY:

CREATININE LEVEL: __________ GFR LEVEL: __________ml/min CONTRAST: __________ CC: __________

IV SITE: ______ IV: ______ # OF PUNCTURES ______ TECH: ______ GAUGE: ______ LOT #: ______ EXP: ______

CONTRAST COVERAGE BY: ______________________________

BLUE STAR IMAGING
At The Star

HIPAA ACCESS TO PROTECTED HEALTH INFORMATION

Have you had a prior imaging study on the body part you are having examined today? ☐ Yes ☐ No

If yes, what type of exam: CT MRI ULTRASOUND X-RAY

Name of the facility where exam was performed: ______________________________

Date of Service: ______________________________

I hereby authorize Blue Star Imaging to request protected health information onmy behalf for comparison purposes.

______________________________ ______________________________
Signature: Date:

______________________________ ______________________________
Print Name: DOB:

Please Note:

At the request of your primary care physician or referring doctor, your health information and images may be visible to other physicians for continuing your patient care. The purpose of the request could be for a consultation, second opinion, and/or referral to a specialist.

It is to be understood by all parties that the permitted uses and disclosures of health information must be within the scope of the obligations and responsibilities for continued medical care, defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

________ By initialing here, you are helping streamine the process and allowing the consulting physician to view your images without further consent.

If you wish NOT to have your images available for continued care, please let the front desk know and we will note your account accordingly.

In addition to the caregiver(s) providing services and my insurance company for payment of claims, I would like for the following person(s) to have access to my protected health information (PHI).

Name(s)	**Relationship to Patient**
______________________________	______________________________
______________________________	______________________________