tolland imaging center

CT Screening Form

Name ______________________ DOB: ____/____/______ Date ______________

Weight: ______________________ Height: ______________________

What are your complaints or symptoms that led you to see your doctor? ______________________

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Have you had any previous surgery on the area of interest? ______________________

If yes, when? ______________ Reason? ______________________

Have you had any previous Radiological exams on the area of interest at a non-ECHN facility? If so, when and where and what type: ______________________

Have you ever had radiation or chemotherapy (when)? ______________________

Please list any medications you are taking: ______________________

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Allergies: ______________________

Yes	No		Yes	No	
☐	☐	Diabetic *	☐	☐	Breast Feeding
☐	☐	Kidney disease *	☐	☐	Cardiac Disease
☐	☐	Only one kidney *	☐	☐	Over 64 in age #
☐	☐	Dialysis	☐	☐	Previous contrast reaction **
☐	☐	Kidney Transplant/Surgery	☐	☐	Asthma requiring medication
☐	☐	Polycystic or sponge kidneys	☐	☐	Beta Blockers (or other HTN medications)
☐	☐	History of kidney cancer			

Note - Many exams require an injection of X-ray contrast. If you are over 64 years old or diabetic we will need to have the results of a kidney function test (blood work) before performing your exam.

*** Recent Creatinine test necessary if answered YES**
**** Check with physician about contrast use with any history of contrast reaction or abnormal GFR**

Female Patients Only:

This is to certify that, to the best of my knowledge, I am not pregnant, and this facility has my permission to perform the diagnostic x-ray examination(s). I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Signature: ______________________ Date: ____________ Time: ____________

Print Name: ______________________

Patient/Parent/Legal Guardian Signature: ______________________ **Date/Time:** ____________

Patient/Parent/Legal Guardian Print Name: ______________________

Technologist Signature: ______________________ **Date/Time:** ____________

Technologist Print Name: ______________________