affidea

RADIOLOGICAL CONTRAST EXAMINATION QUESTIONNAIRE AND CONSENT FORM (CT SCAN, X-RAY)

Name, Surname _____ DOB _____

Type of examination _____ Date _____ Height _____ Weight _____

Before undergoing a radiological examination, with or without the administration of contrast, it is required to fill in the below questionnaire. In case of question/clarification needed, please inform the Radiographer who is going to proceed with your exam.

1. Have you ever had any adverse reaction after CT or X-ray with contrast injection?	**YES**	**NO**
2. Do you have any known allergy in:		
a. Medication	YES	NO
b. Food	YES	NO
c. Other (please specify)	YES	NO
3. Have you had any contrast agent in the last 24 hours?	**YES**	**NO**
4. Do you have any of the following conditions?		
a. Hyperthyroidism	YES	NO
b. Asthma	YES	NO
c. Heart Failure	YES	NO
d. Diabetes mellitus	YES	NO
e. Hypertension	YES	NO
f. Gout	YES	NO
g. Renal disease (including renal surgery, kidney transplantation)	YES	NO
5. Do you currently take any of the following drugs:		
a. Metformin (Glucophage)	YES	NO
b. Interleukin 2	YES	NO
c. Non Steroid Anti-inflammatories	YES	NO
d. Aminoglycosides	YES	NO
e. Beta-blockers	YES	NO
6. Do you have a recent (up to 4 weeks) laboratory creatinine result?	**YES**	**NO**
7. (for female patients):		
a. Are you pregnant or is there any possibility of being pregnant?	YES	NO
b. Are you breast-feeding?	YES	NO

☐ I confirm that I have been fully informed about all stages of the above-mentioned radiology imaging, including contrast media administration and associated risks, and, therefore, **give my consent** to the above-mentioned medical examination **with contrast media administration**. I also confirm that the proposal is entirely medically indicated and recommended and is in accordance with my consent to its performance.

☐ I do not consent to undergo the above-mentioned examination

☐ I confirm that I have been fully informed about all stages of the above-mentioned radiology imaging, including contrast media administration and associated risks, and, therefore, **give my consent** to the above-mentioned medical examination, but **without contrast media administration**. I also confirm that the proposal is entirely medically indicated and recommended and is in accordance with my consent to its performance.

Name of patient or legal representative: _____

Signature of patient (or legal representative): _____

(For Radiographer)

(contrast label)

SeCre: _____

eGFR: _____

_____

Name, Surname of Radiographer:

_____

Signature of Radiographer: