TPCA Tallahassee Primary Care Associates

Our primary care is you.

Computed Tomography (CT) Consent / History Form

Date:_____ Name:_____Age:_____

Ordering Physician:_____

Have you ever had a *previous* CT Scan? **YES** **NO** **Was IV Contrast Used? **YES** **NO**

If Yes, did you experience an allergic reaction to the IV Contrast? **YES** **NO**

****If Yes, please explain in detail**_____

Please briefly describe your current symptoms and how long you have experienced these symptoms:_____ _____

_____

_____

Allergies:_____

List **ALL** previous surgeries:_____

_____

Are you a diabetic? **YES** **NO**
Do you take Glucophage, Glucovance, Metaglip, Avandamet, Metformin? **YES** **NO**

If yes, you will be informed of special instructions prior to leaving your appointment today

*Circle any of the following symptoms that you are **currently** experiencing:*

- Pain
- Difficulty breathing
- Chills
- Weight Loss
- Nausea

Cough
Fever
Vomiting
Diarrhea
Constipation

Coughing up blood/Sputum
Abnormal X-ray results
Shortness of Breath
Chest pain
Sweats

Any possibility you could be pregnant? **YES** **NO** (Please inform technologist verbally, if you answered yes)

Circle any of the following conditions that you have currently or have had in the past:

- Kidney Disease
- Lupus
- Hypertension
- Sickle Cell Anemia
- Multiple Myeloma
- Stroke
- Tuberculosis
- Heart Failure
- Seizures

Prior History or diagnosis of cancer? **YES NO**
**If yes, please explain:_____

Are you currently a smoker? **YES NO** If yes, how long?_____
Do you have a previous smoking history? **YES NO** If yes, how long?_____

Consent For Computed Tomography (CT Scan)

Your physician has ordered a CT of your _____. It is a commonly performed radiology examination, which will provide valuable information and is usually completed in 20 minutes. The examination may require an intravenous injection of contrast material which contains iodine. Very rarely, mild allergic reactions to the injection may occur, which generally disappear without treatment or respond promptly to medication. Severe allergic reactions, including fatalities occur so rarely that your physician feels that any possible risk is far outweighed by the medical information that can be gained by the examination.

Please sign below indicating that all your history/information is correct and you understand/agree to have this examination.

Patient's signature:_____ Date:_____

Witnessed By:_____ Date:_____

The TPCA Diagnostic Imaging Center is licensed by the State of Florida and is accredited by the American College of Radiology. As a provider for Computed Tomography (CT) scans, we are required by law to provide you with a list of alternative CT scan providers in the area. Please speak to your CT technologist regarding a list of alternative CT scan providers and please be advised that in selecting another provider, it will be the sole responsibility of the patient to ensure that the provider is a participating provider with your insurance company.

Please do not write below this line

BUN:_____ Creatinine:_____ Date Drawn:_____

Was the patient premedicated for this exam? YES NO

Was there any contrast reactions involved? YES NO
***If yes, please see EMR*

Contrast material used for this exam:

Oral_____ Rectal_____ IV Contrast_____ IV site:_____

Technologist: Kellie Waring, R.T. (R)(CT) Shannon Carnley, R.T. (N) (CT) Brandy Sills R.T (R) (CT) (MR)