**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?________

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**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: __________________________

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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 Carley, R.T. (N) (CT)  Brandy Sills R.T (R) (CT) (MR)

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