

H.O.P.E. IMAGING

Loma Linda High Field Open MRI & Diagnostic Center

SCREENING FORM

CT

Please complete the following questions as best as you can

NAME : _____ DATE : _____

- | | Yes | No |
|----------------------------------|--------------------------|--------------------------|
| 1. Are you pregnant ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you diabetic ? | <input type="checkbox"/> | <input type="checkbox"/> |
| List Diabetic Medication : _____ | | |
| _____ | | |

- | | | |
|--|--------------------------|--------------------------|
| 3. Have you received iodinated contrast before ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have any allergies ? | <input type="checkbox"/> | <input type="checkbox"/> |
| Please list : _____ | | |
| _____ | | |

- | | | |
|--|--------------------------|--------------------------|
| 5. Do you have history of kidney disease ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have history of lung disease ? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you have history of cancer ? | <input type="checkbox"/> | <input type="checkbox"/> |
| Type : _____ | | |

Patient Signature : _____ Tech Initial : _____

FOR TECH USE ONLY

BUN : _____ CREATININE : _____ DATE DRAWN : _____

IV CONTRAST : _____ AMOUNT : _____

RATE OF INJECTION : _____ IV SITE : _____

REACTION : _____

TREATMENT : _____

TECH/RN SIGNATURE : _____ RADIOLOGIST'S SIGNATURE: _____