HEART OF TEXAS
HEALTHCARESYSTEM
2008 Nine Road • Brady TX 76825-1150 • 325.597.2901

IODINE CONTRAST FORM

Your Doctor has ordered a CT exam which uses Iodine Contrast material:

Name: _____ Date of Birth: _____

Reason for Exam: _____

Have you ever had previous imaging that required injection of contrast media/dye? Yes / No
Have you ever had an allergic reaction to IV Contrast used in any imaging procedure? Yes / No

Do you have any of the following?

Diabetes ..... Yes / No
Asthma ..... Yes / No
Heart disease/problems ..... Yes / No
Lung disease ..... Yes / No
Hypertension (High Blood Pressure) ..... Yes / No
Chronic kidney disease ..... Yes / No
Dialysis ..... Yes / No
Renal (kidney) failure ..... Yes / No
Multiple Myeloma ..... Yes / No
Pheochromocytoma (Adrenal Gland Tumor) ..... Yes / No
Are you taking Glucophage? Glucovance? (Metformin) ..... Yes / No
Are you taking Avandament, Actoplusmet, Fortemet, Riomet, Glumetza, or Janumet? ..... Yes / No
* Metformin-containing medications must be held for 48 hours following the CT exam.*

Patient Signature: _____ Date: _____

TO BE COMPLETED BY TECHNOLOGIST/HOTHCS ONLY ON ALL CONTRAST EXAMS

Patient Fasting? Yes / No Oral Contrast (Gastrografin): Yes / No

Contrast Type Injected: Isoview 300 Volume _____ ml.

IV Access:
IV Started By: _____

Allergy problems post contrast? Yes / No
If yes, complete Contrast Incident Form.
M.D. Notified: Yes / No Time: _____

Date Lab Drawn: _____

Creatinine within normal limits: Yes / No / N/A

Creatinine Level: _____ B.U.N. Level: _____

Comments: _____

_____

Technologist Signature: _____ Date: _____