DI0145

CentraState Medical Center
901 West Main Street, Freehold, NJ 07728-2549

PATIENT LABEL HERE

CAT SCAN DEPARTMENT
OUT-PATIENT INFORMATION SHEET

Today's Date: _____

Patient Name: _____ Appt. Date: _____

Weight: _____ Physician Name: _____

Any allergies to iodine, food or medicines:

_____

_____

Any History of: Please put yes or no!

Diabetes: _____

Hay Fever: _____

Asthma: _____

Patient History / Reason for Exam: _____

_____

_____

Date of last menstrual period: _____

Are you pregnant? _____

Are you breast-feeding? _____

PLEASE BE AWARE IF YOU ARE HAVING A CONTRAST STUDY TO REFRAIN FROM GLUCOPHAGE (METFORMIN), GLUCOVANCE (GLYBURIDE), METAGLIP (GLYPZIDE), AND ADVANDAMENT (AVANDIA) FOR 48 HOURS POST PROCEDURE.

ANY QUESTIONS PLEASE CONTACT YOUR DOCTOR.

HBG 721-021 (11/7/11) 1:1

CONFIDENTIAL

MN0620

CentraState Medical Center
901 West Main Street, Freehold, NJ 07728-2549

OUTPATIENT MEDICATION RECONCILIATION

PATIENT LABEL HERE

ALLERGIES: _____

_____

_____

☐ **On no medication at home**

List all of patient medications prior to admission including OTC, herbal preparations and clinical trial medications:

MEDICATION NAME (Print Legibly)	DOSE	ROUTE	FREQUENCY	Dose Last Taken (date and time)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				
13.				
14.				
15.				
MEDICATION CHANGE AT DISCHARGE		**SENT TO:**		
1.				
2.				
3.				
4.				
5.				

☐ ***NO CHANGE***

SOURCE OF INFORMATION: (check all applicable)

☐ Patient's own medication list
☐ Patient / Family recall
☐ Patient unable to provide history
☐ Pharmacy (name and phone) _____
☐ Physician's List (name) _____
☐ Other (specify) _____

List verified upon admission:

_____ _____

Nurse/Technologist Signature (Date/Time) (Date/Time) Patient / Relative / Guardian

List updated upon discharge:

_____ _____

Nurse/Technologist Signature (Date/Time) (Date/Time) Patient / Relative / Guardian

Comments: _____

_____

HBG 600388 (11/1/11) 1.1

CONFIDENTIAL

DI0075

CentraState Medical Center
901 West Main Street, Freehold, NJ 07728-2549

PATIENT LABEL HERE

DEPARTMENT OF RADIOLOGY
SCREENING FOR ADMINISTRATION OF INTRAVENOUS CONTRAST/DYE

Asthma/Allergy History:

Do you have a history of asthma?	☐ Yes ☐ No
Have you had an asthma attack in the last 24 hours?	☐ Yes ☐ No
Do you use an inhaler or oral medication for asthma on a daily basis?	☐ Yes ☐ No
Have you ever had a severe allergic reaction requiring hospitalization or epinephrine?	☐ Yes ☐ No

Contrast Allergy/Contrast Reaction History:

Have you ever had an allergic reaction to IV contrast/dye?	☐ Yes ☐ No

If yes, explain the reaction and severity: _____

_____

Have you ever been instructed to take a steroid medication prior to receiving IV contrast?	☐ Yes ☐ No
If yes, have you taken a steroid medication in preparation for today's exam?	☐ Yes ☐ No

Medical History

Do you have a history of kidney disease including; (check all that apply)

- __ Dialysis __ Transplant __ Single Kidney __ Renal Cancer __ Renal Surgery

Do you have Diabetes?	☐ Yes ☐ No
Do you take Metformin for Diabetes?	☐ Yes ☐ No
Do you have a history of Sickle Cell Disease?	☐ Yes ☐ No
Do you have a history of Multiple Myeloma?	☐ Yes ☐ No
Do you have a history of Myasthenia Gravis?	☐ Yes ☐ No
Do you have a history of hypertension requiring medical therapy?	☐ Yes ☐ No

Please list all medications you are currently taking:

_____

_____

_____

Are you pregnant? ☐ Yes ☐ No Breast Feeding? ☐ Yes ☐ No (Post IV contrast breast feeding is regarded as safe, although you may choose to wait 4 hours after exam)

INTRAVENOUS CONTRAST DESCRIPTION:
Your physician has ordered an exam which includes the administration of IV Contrast/Dye which is used to enhance imaging. As with any medication, there is a risk of allergic reaction. Very rarely, a mild reaction may occur involving; itching, sneezing or hives. Anaphylaxis, which is extremely rare, may also occur (severe allergic shock which can cause death). We are well equipped to treat and medicate if any reaction occurs. Your doctor has determined that the diagnostic information provided outweighs any potential risk of a reaction.

Our expertly trained clinical staff is available to answer any questions you may have.

Your signature below indicates that you fully understand the explanation given to you in regards to the use of IV contrast for these exams.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _____

TECHNOLOGIST NAME AND ID#: _____

PATIENT NAME (PRINT): _____ **DATE:** _____ **TIME:** _____

PATIENT MEDICAL ID#: _____

HBG MR600-15A (1/26/21) 1.1

CONFIDENTIAL