ASSESSMENT OF RISK WITH IV CONTRAST MEDIA

SECTION A: COMPLETED BY THE NURSE, PROVIDER, OR Technologist

Allergies: __________________________________________________________________________

Height ___________ cm  Weight _________ kg  Ordering Physician: ____________________________

Date: ______________  Time: ______________

1. Has the patient experienced an adverse reaction to IV Contrast Media in the past?

YES NO Comments: ________________________________________________________________

2. Does the patient have a diagnosis of: 

   Renal Impairment or Pheochromocytoma

   Last dose Date: ____________________________

   Time: ____________________________

3. Is the patient taking Metformin? (Glucophage?)

4. Is the patient pregnant or possibly pregnant?

   IF PATIENT IS SCHEDULED FOR A CT, STOP HERE. IF SCHEDULED FOR AN MRI, ANSWER ALL QUESTIONS BELOW

5. Was the patient premature (Less than 34 weeks gestation) or low birth weight (5.5 pounds or less)?

6. Has the patient ever been referred to a Nephrologist or Urologist?

7. Has the patient or a family member ever had Dialysis?

8. Has the patient had a Transplant (including liver, kidney or bone marrow)?

9. Has the patient ever had Liver Disease?

10. Has the patient ever received Chemotherapy or Immunosuppressive Therapy?

11. Has the patient ever had: Heart Disease, Diabetes, Hypertension, Sickle Cell or Thalassemia?

    (If “YES”, circle condition above)

12. Has/Is the patient taking any of the types of medications listed on the back of this form?

Name/relationship to patient of person providing this history ___________________________

Nurse or Provider completing form (name/date/time) ____________________________________

If the answer is YES to any questions, a serum creatinine result is required for CT and/or for GFR calculation prior to administration of Gadolinium.

Results of a serum Creatinine performed within the past 6 months:

Date of Test: ___________  Serum Creatinine Result: ___________  Calculated GFR: ___________

If no results in last 6 months, obtain an order for Serum Creatinine from inpatient provider or outpatient radiologist.

SECTION B: COMPLETED BY RADIOLOGY

Technologist Review (Signature/Date/Time): ________________________________

Technologist Review (Printed Name): _________________________________________

Radiologist Review (Signature/Date/Time): ________________________________

Radiologist Review (Printed Name): _________________________________________

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Examples of medication for the screening questions on Page 1

Generic (Brand / Trade Names)

**ANEMIA MEDICATIONS:**
- ERYTHROPOETIN (EPOGEN, PROCIRIT)
- DARBEPOETIN ALPHA (ARANESP)

**ANTI–HYPERTENSIVES (BLOOD PRESSURE MEDICATIONS):**
- ISRADIPINE, NICARDIPINE (DYNACIRC, PROCARDIA, CARDENE)
- LISINOPRIL, ENALAPRIL, CAPTOPRIL, RAMIPRIL (PRINIVIL, ZESTRIL, VASOTEC, CAPOTEN, ALTACE)
- LOSARTAN, VALSARTAN, Candesartan, Irbesartan (COZAAR, HYZAAR, DIOVAN, ATACAND, AVAPRO)
- ALISKIREN (TEKTURNA)
- ATENOLOL, METOPROLOL, PROPRANOLOL, LABETALOL (TENORMIN, LOPRESSOR, TOPROL, INDERAL, NORMODYNE, TRANDATE)
- CLONIDINE (CATAPRES, DURAACLON)
- HYDRAZIDES, MINOXIDIL (APRESOLINE, LONITEN)
- PRAZOSIN (MINIPRESS)
- PHENOXYPHENAZINE (DIBENZYLINE)

**CHOLESTEROL–LOWERING MEDICATIONS:**
- ATORVASTATIN (LIPITOR)
- LOVASTATIN (MEVACOR)
- PRAVASTATIN (PRAVACHOL)
- SIMVASTATIN (ZOCOR)

**DIURETICS:**
- FUROSEMIDE (LASIX)
- HYDROCHLOROTHIAZIDE (HCTZ, ORETIC)
- CHLOROTHIAZIDE (DIURIL)
- AMELIORIDE (MIDAMOR)
- METOLAZONE (ZAROXOLYN)
- CHLORTALIDONE (THALITONE)
- TORSEMIDE (DEMADEX)
- BUMETANIDE (BUMEX)
- ACETAZOLAMIDE (DIAMOX)

**IV IRON (NOT FORMULATIONS BY MOUTH):**
- IRON SUCROSE (VENOFER)
- SODIUM FERRIC GLUCONATE COMPLEX (FERRLECIT)

**NSAIDS** (TAKING CONSISTENTLY, MORE THAN ONCE PER WEEK?)
- IBUPROFEN (MOTRIN, ADVIL)
- NAPROXEN (NAPROSYN, ALEVE)
- KETOROLAC (TORADOL)
- INDOMETHACIN (INDOCIN)

**PHOSPHORUS–LOWERING MEDICINES**
- CALCIUM ACETATE (PHOSLO)
- CALCIUM CARBONATE (NOT AS A CALCIUM SUPPLEMENT)
- SEVELAMER (RENAGEL, RENVELA)