SOUTH COAST RADIOLOGY | DARLING DOWNS RADIOLOGY | MACKAY RADIOLOGY | THE WOMEN'S IMAGING CENTRE

CONTRAST QUESTIONNAIRE AND INFORMATION FORM

YOUR EXAMINATION MAY INCLUDE AN INJECTION OF CONTRAST MEDIUM (X-RAY DYE).

Please circle your response - either Yes or No.

Height: _____ **Weight:** _____

Please read carefully and circle answers

1. Have you ever suffered asthma requiring hospital admission? ☐ YES ☐ NO

If yes, give details? _____

2. Have you ever had a severe allergic reaction requiring medical treatment? ☐ YES ☐ NO

If yes, give details? _____

3. Have you ever had a reaction to X-ray dye? ☐ YES ☐ NO

If yes, give details? _____

4. Are you being treated for kidney disease or myeloma? ☐ YES ☐ NO

If yes, give details? _____

5. Do you take any oral diabetic medication, especially Metformin? ☐ YES ☐ NO

Example: Metformin, Diabex, Glucophage

If yes, give details? _____

6. Have you had Chemo within the last 2 months? ☐ YES ☐ NO

7. Is there any chance of you being pregnant? ☐ YES ☐ NO

8. What time did you last eat? _____:_____**am/pm**

It is important for you to understand the risks and possible implications that can be associated with this medical procedure. Occasionally, mild allergic reactions such as rash, sneezing and/ or hives may occur. Less commonly, nausea, chills, sweating and vomiting may occur. Usually these symptoms will occur at the time of the procedure but occasionally they may occur later as a delayed reaction, most often in the first 30 minutes after the injection is given.

Very rarely more severe reactions may occur, including asthma, shock and circulatory disturbances, which may require intensive treatment. In approximately 1:250,000 injections of non-ionic contrast, there has been a fatal outcome. Overall, it is considered an extremely safe procedure. Your doctor has considered this diagnostic test to be important for your management. You are advised to remain in our waiting room for 30 minutes post injection for observation.

PLEASE FEEL FREE TO ASK THE DOCTOR OR NURSE FOR ANY FURTHER INFORMATION YOU REQUIRE BEFORE PROCEEDING WITH YOUR X-RAY EXAMINATION.

NAME (please print) _____ **SIGNATURE** _____ **DATE** _____

CONTRAST QUESTIONNAIRE AND INFORMATION FORM Please read carefully and circle answers

Prednisone Tablets 25mg (if required):

Take 2 tablets 1800hrs (6:00pm)_____. (date)

Take 2 tablets 0600hrs (6:00am)_____. (date)

Doctors signature: _____

Date: _____

1. Is patient currently taking prednisone? Yes / No

If YES, dose?_____ mgms

2. Is the patient currently taking any antibiotics? Yes / No

If YES, why?_____

_____

Radiologist	
Nurse	
Contrast administered	
Reaction (describe)	
Treatment prescribed	

Time	BP	Respiration	Pulse

PATIENT LABEL