HOUSTON DIAGNOSTICS
AND PET/CT CENTER
1220 Bialock, Suite 100, Houston, Texas 77055

Name:_____ MR#:_____ Date:_____

Physician:_____ DOB:_____ LMP:_____

CT PATIENT HISTORY

Height:_____ Weight:_____

Chief Complaint: _____

_____

Next appointment with your referring physician: Date _____ Time _____

Are you experiencing pain or other symptoms? Yes ____ No ____

If yes, please describe: _____

_____

Do you have any other tests or procedures performed for the same symptom(s)? Yes ____ No ____

If yes, please list exam(s) and where it (they) was (were) done: _____

_____

_____

Do you have any history of cancer? Yes ___ No ___

If yes, please describe which part(s) of the body: _____

_____

Are you allergic to:

Medications Yes ___ No ___ Please list: _____

Iodine Yes ___ No ___ Please list: _____

Have you had surgery in the past? Yes ___ No ___

If yes, please list all and indicate the year performed:

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

_____ Date _____

Do you have a history of trauma or injury to any part of your body in the recent past?

Yes ___ No ___ If yes, please describe _____

_____

_____

FOR INTERNAL USE ONLY

DX: _____ Symptoms _____

Previous Reports Yes ___ No ___ Faxed to Reading Radiologist? Yes ___ No ___

Comparison Studies Yes ___ No ___ Dates: _____

HOUSTON DIAGNOSTICS
AND PET/CT CENTER
1220 Blalock, Suite 100, Houston, Texas 77055

Name:_____ MR#:_____ Date:_____

Physician:_____ DOB:_____ LMP:_____

CT QUESTIONNAIRE

1. IODINATED CONTRAST ALLERGY?	YES	NO
2. HISTORY OF DIABETES?	YES	NO
3. IS THE PATIENT ALLERGIC TO IODINE OR SEAFOOD?	YES	NO
4. IS THE PATIENT DIABETIC?	YES	NO
5. IS THE PATIENT ON GLUCOPHAGE?	YES	NO

CONTRAST: VOL_____cc TYPE_____

Comments:_____

_____

_____

_____

_____
Technologist

HOUSTON DIAGNOSTICS
AND PET/CT CENTER
1220 Blalock, Suite 100. Houston, Texas 77055

Name:_____MR#:_____ Date:_____

Physician:_____DOB:_____LMP:_____

CONTRAST FORM / FORMA DE CONTRASTE

Test to be performed CT_____

Tipe de examen requerido CT_____

Contrast agent or pharmaceutical to be used: for a CT **OMNIPAQUE**

Contraste o farmaceutico para ser utilizado: para CT **OMNIPAQUE**

I (name of patient)_____give my permission to receive the intravenous and oral examination of OMNIPAQUE for the above stated and prescribed diagnostic imaging test. I have been clearly explained of the potential risks and complications in reference to the administration of these pharmaceutical agents and I have been told that the reaction can range from a minimal or minor skin rash to more severe reactions that may require intense therapy and hospitalization, and the outcome can be unpredictable.
PATIENT SIGNATURE, GUARDIAN OR PERSON LEGALLY IN CHARGE OF A MINOR OR DISABLED PATIENT.

SIGNATURE_____DATE_____

Yo (nombre del paciente) _____ doy mi autofizacion para recibir ya sea en forma oral o a traves de la vena el material de contraste OMNIPAQUE requerido para la prueba de imagen a la que voy a ser sometido. Ya se me han explicado los riesgos y las complicaciones potenciales associadas con la administration de este material de contraste. Tambien se me ha explicado que las reacciones pueden ser minimas como una urticaria o mas severas que podrian requerir terapia o hasta una hospitalizacion, siendo todo esto impredecible.
FIRMA DEL PACIENTE, TUTOR O PERSONA LEGALMENTE RESPONSABLE DE UN PACIENTE MENOR O INCAPACITADO

FIRMA_____FECHA_____