

**CONTRAST USE SAFETY CHECKLIST (PART A - PATIENT SCREENING)**  
**Naval Health Clinic, Charleston Radiology Department**

Please complete this form to aid in safety screening prior to your procedure. Contrast material containing iodine related products may be injected into a vein, circulated in the blood stream, and removed from the blood by the kidneys. The solution is opaque and highlights certain structures in the organ to be studied. There are possible complications associated with many x-ray procedures: some minimal, some severe. Patients may develop a feeling of warmth and/or unusual taste, which is normal and passes quickly. Occasionally, a patient may develop various complications including, but not limited to, minor nausea, hives, a decrease in blood pressure, difficulty breathing, and very rarely, cardiovascular collapse and/or death. The radiologist and technologists are aware of these possibilities and emergency equipment and drugs are readily available if necessary. Your doctor is aware of the risks and has determined that the diagnostic benefits outweigh the potential risks involved. If you have any questions, please do not hesitate to ask the technologist or a radiologist who will be performing the study.

**Patient's Name:** \_\_\_\_\_ **Phone #:(**\_\_\_\_\_)\_\_\_\_\_

**Age/birth date:**\_\_\_\_\_/\_\_\_\_\_ **Weight:**\_\_\_\_\_ **Height:**\_\_\_\_\_ **Sex:**\_\_\_\_\_

**Exam ordered:**\_\_\_\_\_ **Diagnosis / Question:**\_\_\_\_\_

**Referring source( MD /clinic):**\_\_\_\_\_

**Please list all allergies (medications, latex, barium sulfate, foods):**\_\_\_\_\_

\_\_\_\_\_

**List any undocumented medications currently taking:**\_\_\_\_\_

\_\_\_\_\_

- |  |  |
|--|--|
| <p>1. <b>Y N</b> Are you pregnant or breast feeding?</p> <p>2. <b>Y N</b> History of asthma or allergy?</p> <p>3. <b>Y N</b> Diabetic?</p> <p>4. <b>Y N</b> History of heart trouble or hypertension or EF &lt;45%?</p> <p>5. <b>Y N</b> Disease of bone, bone marrow or multiple myeloma?</p> <p>6. <b>Y N</b> Kidney disease or kidney problems?</p> <p>7. <b>Y N</b> Are you taking any type of chemotherapy, diuretic, NSAID, ACE inhibitor, or ARB medication?</p> <p>8. List Any Prior Surgeries_____</p> <p>_____</p> | <p>9. <b>Y N</b> History of bowel obstruction or bowel surgery?</p> <p>10. <b>Y N</b> History of pheochromocytoma (tumor of adrenal gland) or myasthenia gravis?</p> <p>11. <b>Y N</b> Prior stomach/bowel perforation?</p> <p>12. <b>Y N</b> History of hyperthyroidism or thyroid cancer?</p> <p>13. <b>Y N</b> Sickle cell disease or blood diseases or cirrhosis?</p> <p>14. <b>Y N</b> History of an organ transplant?</p> <p>15. <b>Y N</b> Have you ever had any reaction to radiology contrast or dye?</p> |
|--|--|

**Patient's signature:**\_\_\_\_\_ **Date:**\_\_\_\_\_

**CONTRAST USE SAFETY CHECKLIST (PART B - STAFF SCREENING)**  
**Naval Health Clinic, Charleston Radiology Department**

**PRE CONTRAST ADMINISTRATION CHECK LIST:**

- |   |            |           |
|---|------------|-----------|
| 1. Did the patient answer yes to any question in <b>part A</b> ?<br>(If yes consult attending radiologist <b>BEFORE</b> administration of contrast) | <b>Yes</b> | <b>No</b> |
| 2. Patient allergies/medications reconciled and reviewed with medical record and patient to avoid complications with exam?                          | <b>Yes</b> | <b>No</b> |
| <b>REVIEWED BY:</b> _____   |            |           |
| 3. Patients identification verified by comparing record with patient's name and date of birth?  | <b>Yes</b> | <b>No</b> |

**SCREENING LAB WORK RESULTS:**

Cr:\_\_\_\_\_ BUN:\_\_\_\_\_ GFR:\_\_\_\_\_ Pregnancy:    Y    N    Other:\_\_\_\_\_

**RADIOLOGIST'S EXAM PROTOCOL**

**Exam/views:** \_\_\_\_\_

- \_\_\_\_ Ultravist (Iopromide 300 mg/ml) give \_\_\_\_\_ ml IV.  
\_\_\_\_ Barium Sulfate Suspension (ReadiCat2 Banana smoothie: 2.1%w/v, 2.0% w/w) give 900 ml orally with prep instructions.  
\_\_\_\_ Gastroview (367 mg/ml) give \_\_\_\_\_ ml orally.  
\_\_\_\_ Barium Sulfate Suspension give \_\_\_\_\_ ml orally.  
\_\_\_\_ Omnipaque 180 give \_\_\_\_\_ ml intratheacally.  
\_\_\_\_ Omnipaque 240/5cc, Magnevist .15cc, Sodium Chloride 0.9%/10cc

\_\_\_\_\_  
Keith Hanley, M.D.  
CDR. MC. USN

**Radiologist's signature/date/stamp**

**CONTRAST UTILIZED**

\_\_\_\_\_ ml of \_\_\_\_\_ contrast was administered via  
(dose) (type)

\_\_\_\_\_ at \_\_\_\_\_ on \_\_\_\_\_  
(route & site) (time) (date)

Contrast Lot#: \_\_\_\_\_ Expiration date: \_\_\_\_\_ Visual Check  \_\_\_\_\_

Contrast Lot#: \_\_\_\_\_ Expiration date: \_\_\_\_\_ Visual Check  \_\_\_\_\_

IV contrast administered by: \_\_\_\_\_

Administered under the direct supervision of: \_\_\_\_\_

Post injection complications (if any): \_\_\_\_\_

Treatment rendered including any medication given and time: \_\_\_\_\_

Technologist signature/comments: \_\_\_\_\_/\_\_\_\_\_