HARLEY STREET MEDICAL CENTRE

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CT SAFETY QUESTIONNAIRE & CONSENT FORM

Full name: _____ Date of Birth: _____ Male / Female / Undisclosed

AS PART OF YOUR CT SCAN IT MAY BE NECESSARY FOR YOU TO TAKE A PREPARATON WHICH CLEARS OUT YOUR BOWEL AND/OR HAVE AN INJECTION OF CONTRAST; A CLEAR DYE, USED TO HELP DIFFERENTIATE BETWEEN ORGANS IN THE BODY. PLEASE ANSWER THE BELOW QUESTIONS AS ACCURATELY AS POSSIBLE TO ENSURE IT IS SAFE TO ADMINISTER THESE SUBSTANCES TO YOU.

	YES	NO	CLINICAL REF ONLY
1. **FEMALE PATIENTS: Date of last menstrual period:** _____ **Are you pregnant?**	☐	☐	☐
Are you breastfeeding?	☐	☐	☐

IF YOU HAVE BEEN TOLD YOU WILL BE RECEIVING CONTRAST, PLEASE ANSWER QUESTIONS 2 TO 13 BELOW:

	YES	NO	CLINICAL REF ONLY
2. Have you EVER had a CT scan?	☐	☐	☐
3. Have you EVER had a contrast media or dye injection as part of a CT scan?	☐	☐	☐
4. Are you allergic to iodine and / or anti-coagulant drugs?	☐	☐	☐
5. Do you have any other known allergies? *If yes please list here:*	☐	☐	☐
6. Have you EVER had an allergic reaction to a contrast media or dye injection?	☐	☐	☐
7. Have you EVER had any heart surgery?	☐	☐	☐
8. Are you asthmatic?	☐	☐	☐
9. Are you taking any medication?	☐	☐	☐
10. Do you take Metformin?	☐	☐	☐
11. Are you currently taking beta blockers such as Metoprolol or Verapamil?	☐	☐	☐

12. **Do you suffer from any of the following? Please read carefully and circle any that apply to you:**

- High or low blood pressure
- Heart problems including stent insertion or surgery
- Diabetes
- Kidney problems or renal surgery
- Respiratory disease
- Hyperthyroidism
- Severe liver impairment
- Epilepsy
- Gout
- Glaucoma
- Myeloma
- Myaesthenia gravis
- Interleukin 2
- Sickle cell disease
- Adrenal gland tumour

13. **MALE PATIENTS: Do you have an enlarged prostate and / or urinary retention?** ☐ ☐

14. **PLEASE ANSWER IF YOU HAVE BEEN ASKED TO TAKE A BOWEL PREPARATION AS PART OF YOUR CT SCAN.**
Do you suffer from any of the following? Please read carefully and circle any that apply to you:

- Acute inflammatory bowel disease
- Abnormal ulcers, perforation or retention
- Toxic colitis
- Reduced potassium blood level
- Increased magnesium level
- Fructose intolerance

PATIENT DECLARATION – I CONFIRM THE ABOVE DETAILS ARE CORRECT AND CONSENT TO THE CT SCAN, INCLUDING ANY INJECTION REQUIRED AS PART OF THE PROCEDURE:

Patient Signature: _____ **Date:** _____

Parent/Guardian Name & Signature (if patient is under 16): _____

RADIOGRAPHER DECLARATION – JUSTIFICATION FOR IONIZING RADIATION INVESTIGATIONS; I CONFIRM I HAVE DISCUSSED AND CHECKED WITH THE ABOVE NAMED PERSON THE ASSOCIATED RISKS:

Radiographer Signature: _____ **Date:** _____