

Patient Checklist

Iodinated Contrast Administration

Medical Imaging Department

Patient details
- label here

Procedure:

PATIENT QUESTIONS	CLINICAL NOTES:
1. Have you ever had a contrast injection? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - Was it in the past 3 days? Yes <input type="checkbox"/> No <input type="checkbox"/>	<div style="border: 1px solid red; padding: 5px; margin-bottom: 5px;"> Creatinine: _____ Date: _____ eGFR: _____ </div> Clinician use: (contrast label / notes)
2. Have you ever had a reaction to a contrast injection? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - How long ago? - Name of Contrast (if known) - Describe what happened to you	
3. Do you have a history of asthma? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - What medication do you take? - When last did you take it?	
4. Do you have any allergies? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - List allergies	
5. Do you have diabetes? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes - Do you take Metformin? Yes <input type="checkbox"/> No <input type="checkbox"/> - When last did you take it?	
6. Do you have a history of kidney problems? Yes <input type="checkbox"/> No <input type="checkbox"/>	
7. Do you have a history of thyroid problems? Yes <input type="checkbox"/> No <input type="checkbox"/>	
8. Do you have a history of heart problems or high blood pressure? Yes <input type="checkbox"/> No <input type="checkbox"/>	
9. If Female: - Are you pregnant or is there any chance that you are? Yes <input type="checkbox"/> No <input type="checkbox"/> - Are you breast feeding ? Yes <input type="checkbox"/> No <input type="checkbox"/>	
10. Do you have pheochromocytomas or paragangliomas? Yes <input type="checkbox"/> No <input type="checkbox"/>	
11. Have you taken any other medications in the last week? Yes <input type="checkbox"/> No <input type="checkbox"/>	
I have answered the above questions to the best of my knowledge, I have read the contrast factsheet and I have completed the contrast consent form. I have no further questions and I wish to proceed with the procedure including contrast injection.	
Patient signature _____ Date _____	Date: _____ Time: _____
Time out conducted? Yes <input type="checkbox"/>	
Administering clinician signature: Print name:	Checking clinician signature: Print name:
Medical Officer signature: * Print name:	

Major reference: RANZCR Guidelines March 2009

Note: This checklist determines when a Radiologist is to be re-consulted, viz. if any questions 1-10 answered 'Yes'

* Imaging Doctor to sign if contrast going ahead with co-morbidities identified and/or dose changed from standing orders