



**CT Questionnaire**

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Body Part to be Examined: \_\_\_\_\_ Reason for MRI / Symptoms: \_\_\_\_\_

**1. Have you ever had prior surgery, operation, or procedure of any kind?** YES NO

<i>If yes, please list:</i>	<i>Side (Circle One)</i>	<i>Doctor</i>	<i>Date</i>	<i>Facility (if not sure give town)</i>
Type: _____	Left / Right / Both / NA _____	_____	_____	_____
Type: _____	Left / Right / Both / NA _____	_____	_____	_____
Type: _____	Left / Right / Both / NA _____	_____	_____	_____
Type: _____	Left / Right / Both / NA _____	_____	_____	_____

**2. Have you ever had a prior diagnostic imaging study or examination?** YES NO

<i>If yes, please list:</i>	<i>Body Part</i>	<i>Side (Circle One)</i>	<i>Date</i>	<i>Facility (if not sure give town)</i>
MRI	_____	Left / Right / Both / NA _____	_____	_____
CT	_____	Left / Right / Both / NA _____	_____	_____
X-ray	_____	Left / Right / Both / NA _____	_____	_____
Ultrasound	_____	Left / Right / Both / NA _____	_____	_____
Nuclear Med.	_____	Left / Right / Both / NA _____	_____	_____
Other	_____	Left / Right / Both / NA _____	_____	_____

- Is there any chance you may be pregnant? YES NO
  - When was your last menstrual period? \_\_\_\_\_
- Any personal history of cancer? YES NO
  - If so when, type, and treatment: \_\_\_\_\_

**If this is a joint CT please answer these questions:**

1. What is your chief complaint for visiting us today? \_\_\_\_\_  
\_\_\_\_\_
2. What does your doctor think is causing the problem? \_\_\_\_\_  
\_\_\_\_\_
3. Was this the result of an accident or injury? YES NO  
If yes, how long ago was your injury? \_\_\_\_\_  
Please describe what happened: \_\_\_\_\_  
\_\_\_\_\_
4. Do your symptoms involve a certain area of the joint? YES NO  
If yes, where? (inside, outside, front, back) \_\_\_\_\_
5. If there was no injury, are the symptoms related to overworking the joint as a result of your job, sport, or hobby? YES NO  
If yes, what specific motion does your activity require: \_\_\_\_\_
6. If you answered no to questions 3 and 5, what other known conditions do you think could account for your symptoms? (arthritis, cancer, e.g.) \_\_\_\_\_
7. Are your symptoms aggravated by any certain movement or activity? YES NO  
If yes, please describe: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Scheduler Initials: \_\_\_\_\_

Tel: 610-865-4880

Fax: 610-997-7173

**Authorization/Consent for Treatment With Contrast**

1. \_\_\_\_\_ (Please initial) I authorize a qualified representative of Coordinated Health Systems to inject me with a contrast medium for the purpose of attempting to secure additional diagnostic information during my imaging study. I understand that the contrast medium injection will be done by needle and syringe into the joint or by IV.
2. \_\_\_\_\_ (Please initial). I understand that: (a) there is a remote risk of death or serious disability associated with any medical procedure; (b) the following are some other risks that may occur with this procedure: allergic reaction, bruising, swelling, nerve damage and infection; and (c) these may result in temporary or permanent injury, impairment, disability or death or the need for additional procedures.
3. \_\_\_\_\_ (Please initial). I understand that I should immediately report any feelings of discomfort that I believe may possibly be related to the injection to a qualified representative of Coordinated Health Systems. I also understand that I should immediately contact my primary care physician or go to an emergency room if a qualified representative of Coordinated Health Systems is not available.
4. \_\_\_\_\_ (Please initial). Prior to the imaging study, I read and answered the imaging questionnaires of Coordinated Health System, to the best of my ability. Further, I disclosed all of my allergies, previous surgeries, and current medications (prescription and over-the-counter) on said questionnaire. If I had any questions or uncertainty about the requested information, I noted it and understand that I must speak with a qualified representative of Coordinated Health Systems about it before the imaging study.
5. \_\_\_\_\_ (Please initial). The above procedure and its risks have been explained to my satisfaction. I agree that it may be presumed that all of my questions and requests for information were answered to my satisfaction if I undergo the above procedure, because I understand that I have the right to cancel the procedure at any time.
6. I have read this consent and its contents have been fully explained to me. I hereby certify that I understand the contents of the consent and that I am signing it voluntarily.

\_\_\_\_\_  
Signature of Patient or Legal Guardian/Relationship

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

I have provided the patient and/or family with the information concerning the possible risks, complications and alternative methods of treatment

**Arthrogram / IV Contrast Questionnaire**

Name: \_\_\_\_\_

Study Ordered: **MRI Arthrogram**    **CT Arthrogram**    **Contrast MRI**    **Contrast CT**  
(Please circle one)

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Cardiologist: \_\_\_\_\_ Phone: \_\_\_\_\_

**Please answer the following questions as completely as you can:**

- |  |     |    |
|--|-----|----|
| 1. Are you over the age of 60?   | Yes | No |
| 2. Are you diabetic?   | Yes | No |
| If yes, are you taking Metformin/Glucophage/Glucoavance/Avandamet/Metaglib?  | Yes | No |
| 3. Do you have anemia or any disease (s) that affects your blood, a history of renal disease, or seizures?   | Yes | No |
| If yes, please describe: _____   |     |    |
| 4. Do you have any history of kidney problems or kidney transplant? (This includes kidney stones or infections.)   | Yes | No |
| If yes, are you on dialysis?   | Yes | No |
| 5. Do you have any history of liver problems or liver transplant?  | Yes | No |
| 6. Are you currently or have you recently been treated with antibiotics?   | Yes | No |
| If yes, date of last dose: _____   |     |    |
| 7. Do you have any allergies including <b>latex, tape, seafood, shellfish or Iodine</b> ?  | Yes | No |
| If yes, please include symptoms and treatment: _____   |     |    |
| 8. Do you have any medication allergies?   | Yes | No |
| If yes, please list: _____   |     |    |
| 9. Do you have any history of heart disease?   | Yes | No |
| 10. Do you have any history of asthma?   | Yes | No |
| 11. Do you have any history of sickle cell anemia?   | Yes | No |
| 12. Have you had any recent barium studies? If yes, date: _____  | Yes | No |
| 13. Have you had any previous dye studies?   | Yes | No |
| 14. Have you ever had a reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? (e.g. asthmatic, allergic, or respiratory reaction)? | Yes | No |
| If yes, please describe: _____   |     |    |
| 15. Have you recently or are you currently taking any blood thinning medications (e.g. Aspirin, Plavix, Coumadin)?   | Yes | No |
| 16. Please list all medications that you are currently taking (over the counter or prescription):  |     |    |

**Within the past year have you experienced any of these symptoms:**

- |                                      |     |    |       |
|--------------------------------------|-----|----|-------|
| Chest pain or angina                 | Yes | No | _____ |
| Irregular heartbeats or palpitations | Yes | No | _____ |
| Wheezing or chronic cough            | Yes | No | _____ |
| Shortness of breath while lying flat | Yes | No | _____ |
| Excessive tiredness                  | Yes | No | _____ |

**Do you have a history of:**

**Comments:**

Heart disease	Yes	No	_____
High blood pressure	Yes	No	_____
Trouble clotting/ excessive bleeding	Yes	No	_____
Sleep apnea (snoring)	Yes	No	_____
Hiatal hernia, ulcers, reflux	Yes	No	_____
Hepatitis or HIV (AIDS)	Yes	No	_____
Thyroid or adrenal condition	Yes	No	_____
Stroke, TIA, or seizures	Yes	No	_____
Smoking	Yes	No	_____
Other Diseases	Yes	No	_____
Cancer	Yes	No	_____

If yes, when, type, treatment: \_\_\_\_\_

Special Needs of the Patient: \_\_\_\_\_  
(Cultural, Physical, Religious, Medical, Emotional, Communication Barrier)

Due to the potential risk for **Nephrogenic Systemic Fibrosis (NSF)**, which may result in fatal or debilitating systemic fibrosis, those patients that answered yes to questions 1, 2, 3, 4 or 5 will need to obtain blood work (Serum Creatinine/Glomerular filtration rate (eGFR)) **PRIOR** to their contrast study. If you have any questions please ask our staff.

**If blood work is needed:** Lab Location: \_\_\_\_\_ Date: \_\_\_\_\_

**FOR CONTRAST CT STUDIES-** If you are diabetic and taking a medication that contains **Metformin**, it should be discontinued **PRIOR** to your examination. It should not be taken for 48 hours **AFTER** your examination. At that time, your kidney function should be re-evaluated by your physician, and you should not start taking Metformin again until kidney function has been found to be normal. Please refer to the patient information pages supplied to you with the medicine by your pharmacy. In the USA, **Metformin** is sold as a generic drug and is also present within drugs named **Glucophage, Glucovance, Avandamet, and Metaglip.**

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo. I understand that the health care providers who will be performing and/or supervising my MR procedure are relying upon the statements contained in this form in determining whether to undertake the MR procedure and/or to attempt to secure other relevant information before undertaking the MR procedure.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

Scheduler Initials: \_\_\_\_\_

**Technologist Use Only**

Contrast clearance:    Verified                      Not Cleared

IV site/gauge: \_\_\_\_\_ Number of attempts: \_\_\_\_\_ Time given: \_\_\_\_\_

Contrast name/ml: \_\_\_\_\_

Comments/Reaction: \_\_\_\_\_

**Consent to Release Confidential Patient Information to Coordinated Health**

I, \_\_\_\_\_ (patient name), give my permission to \_\_\_\_\_ (name of organization) to release information from my medical record(s) to \_\_\_\_\_ (person) at Coordinated Health for the purpose of patient care.

Please send:

- All records from \_\_\_\_\_ to \_\_\_\_\_ (dates)
- Radiographs
- Laboratory
- Physical therapy
- Operative reports
- Discharge summary
- Radiology reports
- Other (please specify) \_\_\_\_\_

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
Social Security Number

If the patient is a minor, mentally or physically disabled, or deceased, the legally responsible party should sign and date this consent.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date of Signature

\_\_\_\_\_  
Relationship to Patient

*Surgical Specialty Center • Orthopedic Center • Back and Neck Center • Minimally Invasive Spine Center • Hand and Wrist Center  
• Foot and Ankle Center • Imaging Center • Rehabilitation Center • Plastic Surgery Center • Arthritis & Osteoporosis Center*

<input type="checkbox"/> CH Allentown <input type="checkbox"/> CH Surgical Specialty Center <input type="checkbox"/> CH Bethlehem / Corporate <input type="checkbox"/> CH Highland <input type="checkbox"/> CH Easton <input type="checkbox"/> CH East Stroudsburg <input type="checkbox"/> CH Brodheadsville	1401 N. Cedar Crest Blvd 2310 Highland Avenue 2775 Schoenersville Road 2300 Highland Avenue 400 S. Greenwood Avenue 505 Independence Road Rt 115 and Switzgable Drive	Allentown, PA 18104 Bethlehem, PA 18020 Bethlehem, PA 18017 Bethlehem, PA 18020 Easton, PA 18045 East Stroudsburg, PA 18301 Brodheadsville, PA 18322	Phone 610-433-8080 Phone 610-691-4300 Phone 610-861-8080 Phone 610-865-4880 Phone 610-515-8080 Phone 570-420-8080 Phone 570-402-4025	Fax 610-433-4376 Fax 610-691-6257 Fax 610-861-2989 Fax 610-997-7171 Fax 610-515-8080 Fax 570-420-1704 Fax 570-402-3066
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