Capital Health

PATIENT INFORMATION:

Health Card # **DOB: YYYY/MM/DD**

Surname **First name** **Middle Initial** **Telephone #**

CT CONTRAST MEDIA INJECTION QUESTIONNAIRE

If your requisition for CT scan requires a contrast injection, you must:

- **Make a request accompanied with this form, OR**
- **Make a note of any completed eGFR and serum creatinine on the requisition (from within last 6 months for stable outpatients, within one week for all others).**

PATIENT'S RISK FACTORS	**YES**	**NO**
Renal Disease or solitary kidney	☐	☐
Age over 70	☐	☐
Diabetes	☐	☐
Previous Chemotherapy	☐	☐
Organ Transplant	☐	☐
Cardiovascular Disease	☐	☐
Human Immunodeficiency syndrome or AIDS	☐	☐
NEPHROTOXIC DRUG RISK FACTORS:		
NSAIDS	☐	☐
ACE Inhibitors	☐	☐
Angiotensin receptor blockers	☐	☐
Aminoglycosides	☐	☐
Vancomycin	☐	☐
Cancer and immunosuppressant chemotherapy	☐	☐
Others	☐	☐

If you answered yes to any risk factors, you must fax serum creatinine and eGFR from the last 6 months to the CT booking office the original request was faxed to.

eGFR _____

Serum Creatinine _____

eGFR and serum Creatine being ordered _____

Date: YYYY/MM/YY