

**RISK ASSESSMENT FORM FOR ORAL AND IV CONTRAST ADMINISTRATION**

The Following two identifiers were utilized to properly identify the above patient:

1. Asking the patients his/her full name \_\_\_\_\_
2. Asking the patients his/her date of birth \_\_\_\_\_
3. Patients picture ID or hospital wristband \_\_\_\_\_

\_\_\_\_\_ ISOVUE370

Time: \_\_\_\_\_  
\_\_\_\_\_ PO Lopressor

Time: \_\_\_\_\_  
\_\_\_\_\_ mg IV Lopressor

Time: \_\_\_\_\_  
\_\_\_\_\_ mcg SL NTG

LAB DATE: \_\_\_\_\_  
BUN \_\_\_\_\_  
CREAT \_\_\_\_\_  
GFR NBLK \_\_\_\_\_  
GFR BLK \_\_\_\_\_

SERUM CREATININE LEVEL (age>60 within last 30 days)  
SERUM CREATININE LEVEL (age<60 within last 90 days)

CR>1.4 ; GFR <60 to notify physician

Is this a female under fifty?            Y    N  
(Female Fifty and below) HCG within last ten days            Y    N

LAB DATE: \_\_\_\_\_  
HCG \_\_\_\_\_  
(SERUM)

**Cardiac CT Worksheet**

Completed by Nursing Personnel

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

DOB: \_\_\_\_\_ AGE: \_\_\_\_\_ GENDER:    Male            Female

Height : \_\_\_\_\_ ( inches)    Weight: \_\_\_\_\_ (lbs.)            BMI \_\_\_\_\_            BSA \_\_\_\_\_

Diabetic:    Y    N            Glucophage (Metformin):    Y    N

Erectile Dysfunction Medical Therapy within last 48hrs?    Y    N

Risk assessment form completed?    Y    N

Time: \_\_\_\_\_

Heart Rate: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_    Temp \_\_\_\_\_ RR \_\_\_\_\_ O2 \_\_\_\_\_

IV SITE: \_\_\_\_\_            IV GUAGE: \_\_\_\_\_            ALLERGIES:    Y    N

Please call imaging physician when top portion completed