2803 South Avenue, Missoula, MT 59804
phone: 406-327-3950 | fax: 406-327-3955 | toll free: 1-866-image-06

CT PATIENT INTERVIEW

Male ______ Female______
Pregnant Y N

Scheduled with ____
Date of Exam __________________ Phone ___________________ Patient Name ______________________________
DOB _____________________ Weight ______________ Referring Physician _________________________________
Insurance Carrier _________________________________ Referring Physician Phone __________________________
Exam ___________________________________ Clinical Hx & Information ________________________________

Hx of Ca __________________ Type ________________ Previous Surgery _______________________________

Previous Xrays Y N When & Where ____

Previous CT/MRI Y N When & Where ____

BUN ____________________ **Creat** ___________________________ **Date Drawn** ______________________

BUN/Creatinine needs to be drawn on CT patients 60 and older. **If you have the results, please fax results to AI.**

_____Yes _____No Is the patient diabetic?
_____Yes _____No Is the patient taking Glucophage (Metformin) / Glucovance?
CAUTION: IF YES, consult Radiologist before proceeding.
_____Yes _____No Does the patient have a central line (Picc Line, Portacath, Hickman)?

Currently on Medication? Y N If Yes, what type ____

Radiologist Protocol ❑ Routine ____
❑ Non-routine ____

Often times it is necessary to give patients an intravenous injection of CT contrast agent. This contrast does contain a form of iodine. It is necessary that we ask, **do you have any iodine allergies**, asthma, or chronic respiratory problems? Y N

List of Allergies: ____

Parent/Guardian Signature Date Technologist Signature

PLEASE BRING THIS FORM WITH YOU TO YOUR APPOINTMENT ON ______________________ AT___________AM/PM

With W/O Contrast CT	With W/O Contrast CT	CT
☐ ☐ Head	☐ ☐ Pelvis (w/recon)	☐ Pancreas (w/recon)
☐ ☐ Temporal	☐ ☐ Upper Ext.(w/recon) R L	☐ Cardiac Smart Score
☐ ☐ CT Sinus (w/recon)	☐ ☐ Lower Ext.(w/recon) R L	☐ Virt.Colonoscopy screen/diag
☐ ☐ CT Sinus (GE Nav-recon)	**CT**	**✓ CT ANGIOGRAPHY**
☐ ☐ Orbits (w/recon)	☐ Chest interstitial (w/recon)	☐ Head
☐ ☐ Facial (w/recon)	☐ Chest for PE (w/recon)	☐ Neck
☐ ☐ Neck (w/recon)	☐ CT IVP (w/recon)	☐ Chest
☐ ☐ C-Spine (w/recon)	☐ Abdomen (w/recon)	☐ Abdomen
☐ ☐ T-Spine (w/recon)	☐ Renal Stone (w/recon)	☐ Pelvis
☐ ☐ L-Spine (w/recon)	☐ Renal (mass) (w/recon)	☐ Extremity (specify)
☐ ☐ Chest (w/recon)	☐ Liver (w/recon)	☐ Coronary

Miscellaneous Procedure / Comments ____

Physician's Signature Date