New York Private Medical Imaging LLP

CT/ ARTHROGRAM SCREENING SHEET

COMPLETED BY PATIENT

PATIENT NAME: DATE:

DATE OF APPOINTMENT: / / DATE OF BIRTH: / / AGE:

REFERRING PHYSICIAN: PHONE #:

Are you allergic to any of the following?

Seafood or shellfish? ☐YES ☐NO Bee or insect stings? ☐YES ☐NO

Nuts of any kind? ☐YES ☐NO

Do you have allergies any other foods, products or medication? ☐YES ☐NO

If YES, please explain:

Do you have any of the following conditions?

Heart disease? ☐YES ☐NO Multiple myeloma? ☐YES ☐NO

Lung disease? ☐YES ☐NO Diabetes? ☐YES ☐NO

Kidney disease or dysfunction? ☐YES ☐NO Shortness of breath? ☐YES ☐NO

Are you currently on Antibiotic treatment? ☐YES ☐NO

Do you have asthma? ☐YES ☐NO Please describe...

List all medication you take for any of the above:

If you are taking "Glucophage", "Metformin" or "Glucovance" please call New York Private Medical Imaging (212-772-7637) prior to your appointment.

List all previous surgeries with dates:

Have you had a contrast dye injection before? ☐YES ☐NO

Note any problems associated with this IV:

Have you ever been diagnosed with cancer? ☐YES ☐NO

If yes, Radiation Therapy and Dates:

Chemotherapy and Dates:

Are you currently on dialysis? ☐YES ☐NO If YES, date of next session: / /

Date of last menstrual period: / / Are you pregnant? ☐YES ☐NO

Are you currently breast feeding? ☐YES ☐NO

Were you ever a smoker? ☐YES ☐NO If you quit, put approximate date:

APPLIES ONLY TO PATIENTS PRE MEDICATED FOR PROCEDURE

Have you been premedicated for this exam? ☐YES ☐NO Have you finished your medication? ☐YES ☐NO

SCREENED BY: SCREENED WITH:

Technologist comments:

Technologists initials:

I verify that the answers I have provided to questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patients signature: Date: / /

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CT/ ARTHROGRAM CONSENT FORM

***(Please sign at your appointment)** **CONSENT**

As part of my examination, I consent to have intravenous contrast material given to me. This intravenous contrast material is administered through a needle placed in the vein. The indications for this procedure have been explained to me. It has also been explained to me that the potential reactions to contrast, while rare, can include allergic reaction from mild to severe, swelling or infection of the injection site, bleeding, difficulty breathing, low blood pressure and kidney dysfunction.

There are two types of contrast available for use in your examination. The newer, non-ionic contrast agents, are less likely to produce reactions, than agents used in the past. Since the safety of our patients is our primary concern, we no longer use the older ionic contrast. New agents are more expensive and their use adds an additional $125.00 to the cost of the examination. Some insurance companies reimburse the additional cost. By signing below, I agree to pay the additional amount if my insurance company does not reimburse. I further consent to the administration of such drugs, infusions and other treatments necessary in the judgement of the radiologist, should a reaction occur.

Patients Signature: _____

Witness: _____ Date: _____