NSW GOVERNMENT Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION / WARD	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

CT CONTRAST ADMINISTRATION CHECKLIST

SMR060160

For your CT procedure today, you may require the administration of a contrast injection. This contrast helps us to visualise the blood vessels and internal organs, and is often essential in making an accurate diagnosis. The following questionnaire should be completed with the radiographer, nuclear medicine technologist, radiation therapist, nurse or doctor.

Have you been provided with a CT information sheet or had the procedure explained to you? ☐ YES ☐ NO

Age:	Height (cm):	Weight (kg):	Name of procedure and scan region:

PATIENT OR STAFF TO COMPLETE	**YES**	**NO**	**STAFF COMMENTS**
Are you, or is there any chance that you could be **pregnant**?	☐	☐	
Have you ever had a **reaction** after a **contrast injection**? *(itching, skin rash, breathing problems, admission into hospital etc)*	☐	☐	When and what happened?
Do you have any significant **allergies**? *(Significant allergies are anaphylactic reactions, changes in blood pressure, shortness of breath, including multiple allergies)*	☐	☐	If YES, describe: *(for inpatients check medication chart/eMeds)*
Do you have or have you ever had **asthma** or breathing problems?	☐	☐	
If YES, is your asthma unstable or poorly controlled?	☐	☐	
Do you have a history of **kidney problems**? *e.g: chronic kidney disease, kidney failure, single kidney, kidney transplant, dialysis, kidney cancer or surgery?*	☐	☐	If YES, please specify: (STAFF NOTE: eGFR required)
Do you have **diabetes** or problems with blood sugar?	☐ ☐	☐ ☐	(STAFF NOTE: eGFR required) If YES, does the patient take any ***Metformin*** tablets? *(some brands include Diabex®, Diaformin®, Glucobete®, Formet®, Metex XR®).* ***Metformin*** *to be resumed on _____(date)*
Do you have problems with your **thyroid gland**? *e.g. overactive thyroid or thyroid nodules.*	☐	☐	If YES, please specify:
Are you due to have a **nuclear medicine** scan of your **thyroid gland** in the next **8 - 12 weeks**?	☐	☐	*If YES staff to inform the referrer or reschedule*
Do you have any blood related conditions such as sickle cell, myasthenia gravis, phaeochromocytoma, or are you undergoing Interleukin-2 treatment?	☐	☐	
Do you have a cardiac condition? Do you take **beta blockers**? *(some beta blockers include: atenolol, bisoprolol, carvedilol, labetalol, metoprolol, nebivolol, oxprenolol, pindolol, propranolol and sotalol)*	☐	☐	If inpatient, check eMeds
Have your received **chemotherapy** in the last 7 days?	☐	☐	If YES check eGFR
STAFF NOTE: If "Yes" to any of the red flag questions, refer to the radiologist/medical officer for approval and ensure patient is advised of potential risks (Where possible obtain inpatient eGFR within < 7 days, outpatients within < 90 days).	**Refer to the radiologist/ MO**	**Proceed**	**Serum creatinine:** ***micromol/L*** **eGFR:** ***mL/min/1.73 m²*** **Date:**
Emergency CT procedures should not be delayed while waiting for any laboratory tests.			Is eGFR below 45 mL/min/1.73 m²? If YES radiologist/medical officer to consider prehydration

PATIENT SIGN OFF If applicable

I acknowledge that the procedure has been explained to me and that I have answered these questions to the best of my ability.

Patient Print Name _____ Signature _____ Date _____

STAFF COMPLETING FORM

Print Name _____ Signature _____ Date _____

Holes Punched as per AS2828.1: 2012

BINDING MARGIN - NO WRITING

CT CONTRAST ADMINISTRATION CHECKLIST

SMR060.160

NSW GOVERNMENT Health

Facility:

CT CONTRAST ADMINISTRATION CHECKLIST

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

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ORAL CONTRAST ADMINISTRATION (Except Gastrografin)

Oral Contrast required: ☐ Yes ☐ No ☐ N/A

1. Oral contrast name _____ Time: ___:___ Volume: _____
2. Oral contrast name _____ Time: ___:___ Volume: _____
3. Oral contrast name _____ Time: ___:___ Volume: _____

Route : ☐ Oral ☐ naso-gastric tube

Note: please enter in prescription box below if deviating from Standing Order

ALLERGIES & ADVERSE DRUG REACTION (ADR) ☐ Nil Known ☐ Unknown Please enter to an electronic medical record

Drug (or other)	Reaction / Type / Date	Initials	Drug (or other)	Reaction / Type / Date	Initials

Sign ..... Print ..... Date .....

VASCULAR ACCESS: Please complete access details below or ☐ tick if entered in an electronic medical record

a. ☐ Existing access used Site of cannula _____ Cannula gauge _____

b. ☐ New cannula inserted By (name)_____ Date _____ Time ____:____

IV Site: _____ Cannula gauge _____

☐ Cannula removed By (name)_____ Date _____ Time ____:____

c. ☐ Suitable venous access device (CVAD)* used **Access to power injectable devices by accredited staff only*

Affix Contrast Media sticker and Batch Number here

Accessed by_____(initials) Date _____ Time ____:____

De-accessed by_____(initials) Date _____ Time ____:____

☐ Extravasation recorded in IMS no _____

The prescriber is either a valid Standing Order, (SO) or Medical Officer (MO). Complete the STAT PRESCRIPTION below for all cases by writing "SO" under "Prescriber Print name" OR write the name and signature of the radiologist/MO/treating doctor IF no valid SO exists or variation to SO occurs .

STAT PRESCRIPTION - Table of Doses Administered OR recorded in an electronic medical record ☐ tick if electronic

Medication	Dose (mL)	Rate (mL/s)	Freq	Route	Prescriber or Standing Order		Date	Given by (initials)	Checked by (initials)	Date/time
					Print name	Signature				
										/ / :

STAFF NOTES *(e.g. reasons for proceeding if a red flag was identified or direction given by a radiologist/medical officer over the phone). NOTE: Please record Dr's name, date and instructions below.*

☐ Post-Procedure explained

Print name:_____ Designation:_____ Signature:_____ Date:_____

CHECKLIST COMPLETION SIGN OFF (by radiographer/nuclear medicine technologist/authorised nurse/ medical officer as per PD2013_043)

Staff name _____ _____

PRINT NAME SIGNATURE

Staff contact details _____ ____/____/20____ ___:___ Phone: _____

DESIGNATION DATE TIME

INTERPRETER _____ _____ ____/____/20____ ____:____ _____

PRINT NAME SIGNATURE DATE TIME Emp ID/Prov No.

NO WRITING