



FAMILY NAME		MRN
GIVEN NAME		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
D.O.B. ____/____/____	M.O.	
ADDRESS		
LOCATION / WARD		
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE		

Facility:

## CT CONTRAST ADMINISTRATION CHECKLIST

(For IV and oral contrast procedures. Not for use with intra-arterial or CT Cholangiography procedures)

For your imaging 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 an information sheet or had the procedure explained to you?  YES  NO

Age: \_\_\_\_\_ Height (cm): \_\_\_\_\_ Weight (kg): \_\_\_\_\_ Name of procedure/scan region: \_\_\_\_\_

PATIENT OR STAFF TO COMPLETE	YES	NO	STAFF COMMENTS
Are you, or is there any chance that you could be <b>pregnant</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever had a <b>reaction</b> after a <b>contrast injection</b> ? (e.g. <i>itching, skin rash, breathing problems, admission into hospital etc.</i> )	<input type="checkbox"/>	<input type="checkbox"/>	When and what happened?
Have you had any contrast media injections in the last 72 hours?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have multiple or significant <b>allergies</b> requiring medical treatment? (e.g. <i>for anaphylactic reactions, changes in blood pressure, shortness of breath.</i> )	<input type="checkbox"/>	<input type="checkbox"/>	If YES, describe patient's documented allergies:
Do you have unstable or poorly controlled <b>asthma</b> requiring medical treatment? (e.g. <i>severe exacerbations or the need to attend ED.</i> )	<input type="checkbox"/>	<input type="checkbox"/>	If YES, describe:
Do you have a history of <b>kidney problems</b> ? (e.g. <i>chronic kidney disease, kidney failure, single kidney, kidney transplant, dialysis, kidney cancer or surgery?</i> )	<input type="checkbox"/>	<input type="checkbox"/>	If YES, please specify:  (STAFF NOTE: eGFR required)
Do you have <b>diabetes</b> or problems with blood sugar?  If YES, does the patient take any <b>Metformin</b> tablets? (some brands include <i>Diabex®, Diaformin®, Glucobete®, Formet®, Metex XR®.</i> )	<input type="checkbox"/>	<input type="checkbox"/>	(STAFF NOTE: eGFR required)  Patients should have eGFR check prior to the resumption of Metformin. If eGFR is abnormal i.e. < 30 then check eGFR after 48 hrs. Refer OPs to GP for this check.
Do you have problems with your <b>thyroid gland</b> ? (e.g. <i>overactive thyroid or thyroid nodules.</i> )	<input type="checkbox"/>	<input type="checkbox"/>	If YES, please specify:
Are you due to have a <b>nuclear medicine</b> scan of your <b>thyroid gland</b> in the next <b>8 weeks</b> ?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, staff are 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?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you have a cardiac condition? Do you take <b>beta blockers</b> ? (some beta blockers include: <i>atenolol, bisoprolol, carvedilol, labetalol, metoprolol, nebivolol, oxprenolol, pindolol, propranolol and sotalol.</i> )	<input type="checkbox"/>	<input type="checkbox"/>	If an inpatient, check eMeds
Have you received <b>chemotherapy</b> in the last 7 days?	<input type="checkbox"/>	<input type="checkbox"/>	If YES, check eGFR
Is eGFR below 45 mL/min/1.73 m <sup>2</sup> ? If YES, radiologist/medical officer to consider prehydration.	<input type="checkbox"/>	<input type="checkbox"/>	<b>Serum creatinine:</b> _____ <i>micromol/L</i> <b>eGFR:</b> _____ <i>mL/min/1.73 m<sup>2</sup></i> <b>Date:</b> _____

**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).

Emergency procedures should not be delayed while waiting for any laboratory tests.

**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 THIS PAGE**

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



SMR130071

Holes Punched as per AS2828.1: 2019

BINDING MARGIN - NO WRITING

NH700461 250321



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**CT CONTRAST ADMINISTRATION CHECKLIST**  
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**ORAL CONTRAST ADMINISTRATION (Including Barium Sulfates, Gastrografin, other iodinated oral CM and water).**

Oral Contrast required:  Yes  No  N/A

- Oral contrast name \_\_\_\_\_ Time: \_\_\_\_:\_\_\_\_ Volume: \_\_\_\_\_
- Oral contrast name \_\_\_\_\_ Time: \_\_\_\_:\_\_\_\_ Volume: \_\_\_\_\_
- Oral contrast name \_\_\_\_\_ Time: \_\_\_\_:\_\_\_\_ Volume: \_\_\_\_\_

Route :  Oral  Naso-gastric tube

Note: Please enter in prescription box below if using Gastrografin or deviating from existing approved Standing Orders

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

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

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

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

- Existing access used Site of cannula: \_\_\_\_\_ Cannula gauge: \_\_\_\_\_
- Does the patient have an implantable device?
- New cannula inserted By (name): \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_:\_\_\_\_  
 IV Site: \_\_\_\_\_ Cannula gauge: \_\_\_\_\_  
 Cannula removed By (name): \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_:\_\_\_\_
- 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 IIMS/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. events or 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.

(No need to initialise if empty) Initials: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_:\_\_\_\_

**CHECKLIST/COMPLETION SIGN OFF** (by radiographer/nuclear medicine technologist/authorised nurse/ medical officer as per PD2013\_043)

Post-Procedure explained

Staff name \_\_\_\_\_ / \_\_\_\_/20 \_\_\_\_:\_\_\_\_  
 PRINT NAME SIGNATURE DATE TIME  
 Staff contact details: \_\_\_\_\_ Phone: \_\_\_\_\_  
 DESIGNATION

**INTERPRETER** \_\_\_\_\_ / \_\_\_\_/20 \_\_\_\_:\_\_\_\_  
 PRINT NAME SIGNATURE DATE TIME Emp ID/Prov No.

Holes Punched as per AS2828.1: 2019  
BINDING MARGIN - NO WRITING

