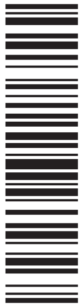
Health

Facility:

FAMILY NAME	MRN
GIVEN NAME	☐ MALE ☐ FEMALE
D.O.B. _______ / _______ / _______	M.O.
ADDRESS	
LOCATION / WARD	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE



SMR130071

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 **pregnant**?	☐	☐	
Have you ever had a **reaction** after a **contrast injection**? *(itching, skin rash, breathing problems, admission into hospital etc)*	☐	☐	When and what happened?
Have you had any contrast media injections in the last 72 hours?	☐	☐	
Do you have multiple or significant **allergies** requiring medical treatment? *(e.g. for anaphylactic reactions, changes in blood pressure, shortness of breath)*	☐	☐	If YES, describe patient's documented allergies:
Do you have unstable or poorly controlled **asthma** requiring medical treatment? *(e.g. severe exacerbations or the need to attend ED)*	☐	☐	If YES, describe:
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? If YES, does the patient take any ***Metformin*** tablets? *(some brands include Diabex®, Diaformin®, Glucobete®, Formet®, Metex XR®).*	☐	☐	(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 **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 weeks**?	☐	☐	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?	☐	☐	
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 an inpatient, check eMeds
Have you received **chemotherapy** in the last 7 days?	☐	☐	If YES, check eGFR
Is eGFR below 45 mL/min/1.73 m²? If YES radiologist/medical officer to consider prehydration	☐ **Refer to the radiologist/ MO**	☐ **Proceed**	**Serum creatinine:** ***micromol/L*** **eGFR:** ***mL/min/1.73 m²*** **Date:**

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 ____________

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ORAL CONTRAST ADMINISTRATION (including Barium Sulfates, Gastrografin, other iodinated oral CM and water)

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 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 ....

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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. ☐ Does the patient have an implantable device?

c. ☐ New cannula inserted By (name)____________________ Date ____________ Time ____:____

IV Site: ______________________________ Cannula gauge ______________________________

☐ Cannula removed By (name)____________________ Date ____________ Time ____:____

d. ☐ 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 ______________________________ ____________________
PRINT NAME SIGNATURE

Staff contact details ____________________ ____/____ /20____ ___:___ Phone: ____________________
DESIGNATION DATE TIME

INTERPRETER ____________________ ______________ ____/____ /20____ ___:___ ______________
PRINT NAME SIGNATURE DATE TIME Emp ID/Prov No.

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