OCMRI
17150 Euclid Street, Suite 101
Fountain Valley, California 92708
(714) 957-0317 FAX: (714) 957-0616

CT SCAN PATIENT INFORMATION

DATE: ____________________

PATIENT NAME: ____________________ CHART NO: ____________
LAST FIRST

AGE: ____________ BIRTH DATE: ____________________ SEX: M / F

HIGHT ____________ WEIGHT ____________ EXAM: ____________

PRIMARY PHYSICIAN: ____________________ PHONE: ____________

REFERRING PHYSICIAN: ____________________ PHONE: ____________

WHAT IS THE **REASON** YOUR DOCTOR **ORDERED** THIS C.T. SCAN?

DO YOU HAVE:	YES	NO
ALLERGIES?	( )	( )
ASTHMA?	( )	( )
KIDNEY FAILURE?	( )	( )
HEART TROUBLE?	( )	( )
DIABETES?	( )	( )
INSULIN DEPENDENT?	( )	( )
ARE YOU ON METFORMIN (GLUCOPHAGE) PILLS?	( )	( )
REACTION / ALLERGY TO X-RAY CONTRAST?	( )	( )
ARE YOU PREGNANT?	( )	( )
CANCER?	( )	( )

ANY **SURGERIES**? ____________________

HAVE YOU HAD PREVIOUS **CT SCANS**? WHERE? ____________________

SIGNATURE: ____________________ **DATE:** ____________

C.T. PATIENT INFORMATION AND CONSENT SHEET

This x-ray examination of the body is done by using a special computer which allows us to view organs which we are not able to visualize using standard x-ray.

Some C.T. examinations require the injection of a contrast media into your bloodstream. The rise of this solution helps us to visualize certain organs inside the body which are not normally seen well and provides the radiologist with information which is necessary in evaluation your exam.

The contrast agent is given through a small needle placed into the vein, usually on the inside of your elbow or on the back of your hand. Contrast media is considered quite safe; however any injection carries a risk of harm including injury to a nerve, artery, or vein, of infection to the material being injected. Occasionally, a patient will have a mild reaction to the contrast material and develop sneezing and/or hives. Uncommonly, more serious reactions have been known to occur, including life-threatening reactions. These reactions are very rare.

Please answer the following questions so that we may evaluate if you are at high risk for adverse effect to the contrast material:

1) Have you ever had an "allergic" like reaction to any contrast material which required treatment?___
2) Do you have allergies or asthma? ______
3) Do you have a history of heart disease or high blood pressure? ______
4) Do you have a history of myeloma sickle cell disease, polycythemia, or pheochromocytoma? ____
5) Do you have history of kidney disease or diabetes? ______
6) Do you have any known allergies to seafood? ______

Your doctor has ordered this C.T. Body Scan to secure more information which will aid in the diagnosis of your condition. If you have additional questions regarding your exam, please feel free to discuss them with the Technologist of Radiologist prior to your scan.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS THEIR AGENT TO GIVE THE CONSENT TO HAVE THE DESCRIBED PROCEDURE PERFORMED.

____

Signature of Patient or Parent/Guardian   Date

PATIENT INFORMATION SHEET

Chart No. ____________

Scan ____________

Insurance ____________

Date and Time of Appointment: ____________________

PATIENT INFORMATION

Patient Name: ____________________ Driver's License No. ____________

Address: ____

City, State Zip: ____________________ Date of Birth: ____________

Telephone (Home): ____________________ Telephone (Work): ____________

Social Security Number: ____________________

Emergency Contact Name ____________________ Telephone ____________

REFERRING SOURCE

Doctor: __________ Chiropractor: __________ Other: __________

Name of Referring Source: ____________________ Telephone: ____________

INSURANCE INFORMATION

Subscriber Name____________________ Subscriber SS#:____________________

Relation to Patient____________________ Policy No.____________________

Primary Ins____________________ **Second Ins**____________________

Group No.____________________ Group No.____________________

Member No.____________________ Member No.____________________

Address____________________ Address____________________

____________________ ____________________

I authorize payment of medical benefits to Orange County MRI for medical services

Signature: ____________________

I also authorize release of medical information to process any claims

Signature: ____________________ Date: ____________________