



**NEW YORK
RADIOLOGY
PARTNERS**

East Manhattan Diagnostic Imaging

P: 212.410.5100 F: 212.410.2500

Union Square Diagnostic Imaging

P: 212.473.2300 F: 212.473.4780

Kingsway Diagnostic

P: 718.758.1500 F: 718.758.2400

Columbus Circle Imaging

P: 212.977.4100 F: 212.977.4271

CONSENT FOR CT SCAN

Name: _____ Date: _____

Your doctor has asked that a CT scan be performed using intravenous contrast material. This is an iodine containing solution that aids in the visualization of your organs and blood vessels, which helps in the diagnosis of pathology in various parts of your body. In order for us to administer this "dye" you must be informed of the possible risks involved.

I have read the above and understand it all.

After injection of the intravenous contrast, most patients feel a sensation of warmth, a funny metallic taste in their throat, transient nausea and a feeling of warmth in the groin. Some patients develop hives and itching, but this is self-limited and rarely needs to be treated with antihistamines. 1 in 500 patients may develop a severe reaction and 1 in 5,000 may have a life threatening reaction, all of which may have to be aggressively treated with medications. These reactions may involve; tightness in the throat; facial swelling; difficulty breathing; drop in blood pressure or even seizure. Generally speaking, intravenous contrast is extremely safe and well tolerated and these reactions are rare.

I have read the above and understand it all.

This attached questionnaire will help us to decide other issues concerning the contrast material, including whether or not you should have it at all. If you have any questions, you will be able to speak to the supervising radiologist. When your questions have been answered or if you do not have any questions, please sign the form below.

I have read the above and understand it all.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS: _____

INTERPRETER: _____

RADIOLOGIST: _____

PHYSICIAN ASSISTANT: _____



PATIENT SATISFACTION SURVEY

We are striving to provide you with the best possible care. Please help us to achieve this goal by taking a few minutes of your time to answer the following questions. In doing so you will help us to provide optimum care for all our patients.

Name: (optional) _____ Date: _____

Email: (optional) _____

Type of examination: _____

Was it easy to schedule your appointment for today's test? ☐ Yes ☐ No

If no, explain why? _____

Was your scheduler: (Check all that apply.)

Courteous? ☐ Yes ☐ No

Attentive to your needs? ☐ Yes ☐ No

Efficient? ☐ Yes ☐ No

Was your examination started on time? ☐ Yes ☐ No

If not, how long did you wait for your examination:

☐ Less than 15 minutes

☐ 15 – 30 minutes

☐ 30 minutes or more

If more than 15 minutes, did someone explain the reason for delay? ☐ Yes ☐ No

Was your receptionist: (Check all that apply.)

Courteous? ☐ Yes ☐ No

Attentive to your needs? ☐ Yes ☐ No

Efficient? ☐ Yes ☐ No

Was the technologist who performed the procedure: (Check all that apply.)

Courteous? ☐ Yes ☐ No

Attentive to your needs? ☐ Yes ☐ No

Efficient? ☐ Yes ☐ No

If your exam required a Radiologist (Doctor): (Check all that apply.)

Courteous? ☐ Yes ☐ No

Attentive to your needs? ☐ Yes ☐ No

Efficient? ☐ Yes ☐ No

Please rate your overall experience. (Circle a number on the scale below to indicate your level of satisfaction)

1 2
Poor

3 4
Fair

5 6
Satisfied

7 8
Very Satisfied

9 10
Excellent

Any additional comments that you can make would be helpful: (The use of names would be helpful.)

☐ Check here if willing to be contacted to provide an online review.

Thank you for taking the time to complete this survey.



**NEW YORK
RADIOLOGY
PARTNERS**

East Manhattan Diagnostic Imaging

P: 212.410.5100 F: 212.410.2500

Union Square Diagnostic Imaging

P: 212.473.2300 F: 212.473.4780

Kingsway Diagnostic

P: 718.758.1500 F: 718.758.2400

Columbus Circle Imaging

P: 212.977.4100 F: 212.977.4271

Instructions for Diabetic Patients Taking Glucophage (Metformin)

- 1) The patient should take their Glucophage (metformin) the morning of the exam, then discontinue for 48 hours. They may resume this medication after their referring physician has determined through a blood test that their kidney function has not deteriorated.
- 2) Patient must contact either Primary Care physician or Nephrologist to schedule an appointment for a blood test to be taken for evaluation of BUN & CREATNINE.
- 3) Patient must then get authorization from Physician to resume using GLUCOPHAGE (METFORMIN) according to the new lab results.
- 4) Patient should drink at least six eight ounce glasses of water on the day of I.V. contrast administration. I have read and understand the above instructions given to me with regards to GLUCOHPAGE.

Radiologist: _____ Date _____

Patient Name (Print) _____ Date _____

Patient Signature _____ Date _____

Witness _____ Date _____



CT INFORMATION SHEET

Name: _____

Date: _____ Height: _____ Weight _____

The following information is needed to help us plan for your study:

Your Age: _____ Your Weight: _____

What symptoms are you having that led your doctor to order this CT scan?

Please list all medications being taken currently: _____

Please answer the following questions:

	Yes	No
Are you a diabetic?	_____	_____
Are you currently taking Glucophage, Metformin, or Glucovance	_____	_____
Are you pregnant, or have you recently given birth?	_____	_____
Are you currently breastfeeding/ nursing?	_____	_____
Have you eaten in the last 4 hours?	_____	_____
Have you ever had difficulty having an IV started (bad veins)	_____	_____
Do you have a vascular access device?	_____	_____
(Example: Portacath: Hickman Catherter, PICC Line)	_____	_____
Have you had any Barium exams in the last week?	_____	_____
Do you have any allergies to food or medicine?	_____	_____
If yes, please list: _____		

Have you ever had a Diagnostic Procedure during which you received IV contrast or "DYE"?

If yes, please list type of test: _____

If you have had a prior injection of contrast, did you have any difficulty at all? _____

Do you have any of the following conditions? _____

Bronchial Asthma _____

High Blood Pressure _____

Recent Heart Attack _____

Angina _____

Heart Failure/ Arrhythmia _____

Diabetes Mellitus _____

Kidney Failure _____

Sickle Cell Anemia _____

Multiple Myeloma _____

Pheochromocytoma _____

Please list any other health conditions you may have. _____



NEW YORK
RADIOLOGY
PARTNERS

East Manhattan Diagnostic Imaging

Union Square Diagnostic Imaging

Dove Open MRI

Kingsway Diagnostic

Columbus Circle Imaging

Morningside Medical

Midtown Medical Pavilion

Central Park Women's Imaging

PREGNANCY CONSENT FORM

Date: _____

This examination requested by my physician is potentially harmful to my pregnancy, and may cause a miscarriage or congenital deformity. I understand this potential risk to the pregnancy and agree to have the examination performed as requested.

Signature of Patient: _____ Date: _____

Signature of Witness: _____ Date: _____