St Peter's Hospital

ST PETER'S HEALTH PARTNERS

INTRAVENOUS CONTRAST SCREENING FORM

Your healthcare provider has ordered an exam that may require intravenous contrast material ("xray dye"). Please respond to the following questions as accurately as possible:

1. Have you ever had a previous problem with IV contrast? **YES** **NO**

If yes, please give details:_____

2. Have you ever had a life-threatening allergic reaction? **YES** **NO**

If yes, please give details:_____

3. Do you have diabetes? **YES** **NO**
4. Do you take any **METFORMIN**-containing medications? **YES** **NO**

(Glucophage, Fortamet, Metaglip, Avandamet, Glucovance, Glumetza, Riomet)

5. Are you on medication for high blood pressure? **YES** **NO**
6. Do you have a history of kidney disease or a single kidney? **YES** **NO**
7. Have you ever had kidney surgery? **YES** **NO**
8. Have you ever been on dialysis? **YES** **NO**
9. Have you ever had an organ transplant? **YES** **NO**
10. Do you have a history of multiple myeloma (bone cancer)? **YES** **NO**
11. Have you ever been told you have protein in your urine (proteinuria)? **YES** **NO**

Patient Signature_____Date_____

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If YES to any question 3 through 11, a current Cr/GFR is suggested (within 90 days).

Cr/GFR_____Date of Labs:_____Please obtain copy of lab report.

If YES to question 1, premedication is recommended for *previous mild or moderate* allergic reaction. IV contrast should be avoided if there is history of prior severe allergic contrast reaction.