CT Scan Department: Pre Examination Questionnaire CT Colonography

Name:

Date of Birth:

Address:

Hospital Number:

Appointment Date: Time:

Wrightington, Wigan and Leigh NHS
NHS Foundation Trust

OUT PATIENT Identification Check
(you must make a 3 point ID check of the patient)

The ID check has been performed HCA ☐

The ID has been checked by

……*Radiographer*

Patient Weight: kg

Protocol & Vetting (you must check the vetting instruction on CRIS)

Examination Protocol:

Clinical Information:

Protocol & Vetting Checked:

Scanned By:

Gastrografin® Oral Preparation 100mls

Is the patient allergic to Iodine?	YES NO
Is the patient allergic to Gastrografin?	YES NO
Does the patient have an overactive thyroid?	YES NO
Has the patient received the information leaflet?	YES NO

Gastrografin® Record of Administration

Lot Number:

Expiry Date:

Checked By:

Checked By:

Authorisation to administer Gastrografin® by Radiologist if contraindication identified

Name of Radiologist: Signature:

Allergy Questionnaire Prior to IV Contrast

	YES	NO
Does the patient have any allergies? *If "yes" the patient can receive contrast media, although the risk of reaction is up to x3 higher than a patient without allergy history*		
Has the patient had a previous reaction to contrast? *If "yes" check historical radiology record and discuss with the radiologist*		
Does the patient have asthma? *If "yes" and the condition is well controlled with medication there is no specific contraindication for contrast media*		
Does the patient take beta-blockers? *If "yes" the patient can receive contrast media, although any reaction that may occur may be more serious, call for help early*		
Does the patient have eczema? *If "yes" the patient can receive contrast media, the risk of reaction is higher in these patients*		
Is the patient diabetic? *If "yes" check renal function result*		
Does the patient have any known renal problems, single kidney, previous dialysis or renal transplant? *If "yes" check renal function result*		
Does the patient have an over-active thyroid gland? *If "yes" check thyroid function if elevated and not on treatment (carbimazole/beta-blocker) refer to radiologist*		

Give details here:

If asthmatic: is the condition well controlled? Y N

Checklist completed by: (Radiographer initials)

COVID free 28 days? Y N

Renal Function:

All out patients undergoing a Post Contrast Examination <u>MUST</u> have a recent renal function result from within 3 months if they have the following history:

- ***Diabetes***
- ***Known renal impairment, previous dialysis, single kidney or kidney transplant***

All out-patients with the above conditions <u>MUST</u> have a renal function result from within 3 months of the appointment date

Renal Function:

(Check renal parameters on HIS or CRIS event comments)

eGFR: ml/min/1.73^2 ……..

Serum Creatinine: µmol: ……..

Sample Date: ……./……./…….

Metformin:

Is the patient taking Metformin for any condition?

YES NO

If YES, does the patient need to stop Metformin for 48 hours after the injection?

YES NO

Authorisation to administer IV Contrast by Radiologist

Name of Radiologist: Signature:

Record of Medicine Administration:

Sodium Chloride 0.9% used for:		**Intravenous Contrast Agents :**	
Checking Cannulae Patency 10mls *(repeat dose as required)*		**Omnipaque 350**	**Volume Injected :** **ml**
"Saline Bolus Chase" **Total Volume Injected:**	**ml**	**Other Contrast** Name : Concentration :	**Volume Injected :** **ml**
Batch Number:		**Batch Number:**	
Expiry Date:		**Expiry Date:**	
Injected By:		**Injected By:**	
Checked By:		**Checked By:**	

Buscopan				
Volume Injected: ml	Batch Number:	Expiry Date:	Injected By:	Checked By: