NSW GOVERNMENT Health
South Eastern Sydney Local Health District

**Facility:**

FAMILY NAME | MRN

GIVEN NAME | ☐ MALE ☐ FEMALE

D.O.B. _____ / _____ / _____ | M.O.

ADDRESS

LOCATION / WARD

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

# IODINE CONTAINING CONTRAST ADMINISTRATION: CHECKLIST

SES130010

For your examination today, you may require the administration of an iodine-containing (X-Ray) contrast. This contrast helps us to visualize the blood vessels and internal organs, and is often essential in making an accurate diagnosis.

There is a small risk of an allergic type reaction to the contrast; most of these reactions are mild. More serious reactions can occur, however they are very uncommon. When contrast is injected, in rare circumstances it can cause kidney problems. There is an increased risk of this if you have kidney disease or are a diabetic, or taking certain medications. If you have any questions or concerns about your examination today please ask our staff.

Weight (kg): Age: Procedure:

| **Do you have ANY of the following? (indicate Yes or No with an 'X' in the box)** | **Yes** | **No** | **Staff Comments:** |
|---|---|---|---|
| Have you ever had a test for which a **contrast medium** or an 'x-ray dye' was administered? e.g.CT scan, Angiogram, Intravenous Pyelogram (IVP) | | | IV Contrast in past 72 hours? ☐ |
| If yes, did this injection produce any **reaction** or problem? If yes, please describe what happened. | | | |
| Do you have any **allergies**? (e.g. medicines or food) If yes, what are they and have you ever required medical treatment for your allergy? | | | Inpatients: Check medication chart/eMEDS ☐ |
| Do you have **asthma**? If yes, is it currently well controlled? | | | |
| Do you have a history of **kidney problems**? e.g. single kidney, kidney transplant, kidney failure, dialysis, kidney cancer or surgery. If yes, specify: | | | **Creatinine**_____**micromol/L** **eGFR:**_____**mL/minute** **Date:**_____**/20**____ **Cr Clearance**_____**/Risk**____**%** |
| Do you have to restrict your daily **intake of fluids**? What is this restriction? | | | |
| Do you have **diabetes**? | | | Inpatients: Check medication chart/eMEDS ☐ |
| If yes, do you take **metformin** therapy? (some brands include Diabex®, Diaformin®, Glucobete ®, Formet®, Metex XR®) | | | Withhold Metformin Yes ☐ No ☐ |
| Do you have **heart disease or high blood pressure** for which you are taking medication? If yes, specify: | | | |
| Do you take **beta blocker** medications? (some beta blockers include: atenolol, bisoprolol, carvedilol, sotalol, labetalol, metoprolol, nebivolol, oxprenolol, pindolol, propranolol) | | | Inpatients: Check medication chart/eMEDS ☐ |
| Do you have problems with your **thyroid gland**? e.g. over-active thyroid or thyroid nodule. If yes, specify: | | | |
| Are you due to have a nuclear medicine scan of your thyroid gland in the next 8 weeks? | | | |
| Do you have any medical conditions such as a phaeochromocytoma, multiple myeloma, Interleukin-2 treatment, sickle cell, myasthenia gravis? | | | |
| If female, is there any possibility that you could be **pregnant**? | | | If yes, consult with radiologist before proceding |
| Do you have an **implantable device** e.g. Port-a cath or PICC line? | | | If yes, consult with staff accredited in CVADS |
| Are you currently receiving chemotherapy? | | | If yes, within the past 7 days? |

Patient Signature _____ _____/_____/20___
Date

Staff member completing checklist _____ _____/_____/20___ ___:___
Print Name Signature Designation Date Time

Interpreter*_____ ___/___/20__ ___:___ *Telephone interpreter, print name & Job Number.
Print Name Signature ID Number Date Time

S0938 090218

Holes punched as per AS2828-2012
BINDING MARGIN - NO WRITING

CHECKLIST

SES130.010

NO WRITING

NSW GOVERNMENT Health
South Eastern Sydney Local Health District

**Facility:**

# IODINE CONTAINING CONTRAST ADMINISTRATION: CHECKLIST

FAMILY NAME

GIVEN NAME ☐ MALE ☐ FEMALE

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COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

**ALLERGIES & ADVERSE DRUG REACTIONS (ADR)**

☐ Nil known ☐ Unknown (tick appropriate box or complete details below)

| Drug (or other) | Reaction/Type/Date | Initials |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Sign.....Print.....Date.....

Oral Contrast required: ☐ Yes ☐ No ☐ N/A

Oral contrast name, time and volume given:

1 _____ Time: ___:___ Volume: _____

2 _____ Time: ___:___ Volume: _____

3 _____ Time: ___:___ Volume: _____

**Prescription**

| Date prescribed | Medication Print generic name | Strength | Route | Dose | Rate | Frequency | Prescriber signature Print name or STO | Given by Print Name Designation | Checked By Print Name Designation | Time given |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

Contrast Sticker

Note: One of the signatures for the Given by/Checked by *must* be the Radiographer performing the scan Clinical Procedure Level 2 to be recorded in Radiology Information System by Medical Radiation Scientist.

**Venous Access**

Existing Peripheral: ☐ Yes ☐ No Suitable for use? ☐ Yes ☐ No

Cannula gauge: _____ Site: _____

If no, new cannula inserted by: _____
Print Name

Gauge: _____ Site: _____ ☐ L ☐ R Insertion date: _____ Insertion Time: _____

**Power Injectable PICC or PORT** ☐ Yes ☐ No ☐ Unsure

**Note:** Confirm the device is power injectable prior to use. Only to be accessed and used by accredited staff

Accessed by: _____ De-accessed by: _____
Print Name Print Name

**Post Procedure Instructions: Observe for delayed contrast reaction.**

**Cannula removed?** ☐ **Yes** ☐ **No**

Staff Comments:

**PLACE THIS FORM IN CLINICAL RECORD OR SCAN INTO RADIOLOGY INFORMATION SYSTEM FOR OUTPATIENTS**



NO WRITING