CT Scan- Females Only
Outpatient Registration Checklist

Thank you for choosing Baylor Diagnostic Imaging Center and The Women’s Imaging Center for your upcoming procedure(s). Baylor Medical Center at Carrollton respects your time and strives to provide you with very good care. To help expedite the registration process and reduce your wait time, please bring the following completed items with you to your appointment:

- Completed Outpatient Preregistration forms for your scheduled test or procedure
  1. CT Scan Outpatient Registration Checklist (this form)
  2. Patient History for Contrast Media Questionnaire (CT)
  3. Outpatient Questionnaire/ Falls Assessment
  4. Radiology Screening, Childbearing Age (females 12-55 years of age only)
  5. Ionizing Radiation Pregnancy Consent for Treatment (females 12-55 years of age only)

- Insurance Card
- Government Issued Identification
- Insurance co-payment
- Physician orders, if applicable

Baylor Diagnostic Imaging Center at Carrollton and The Women’s Imaging Center provide many diagnostic and screening procedures. Every procedure is overseen by a specialist who will provide patient-centered care. As people are all different, the amount of time each individual needs for their procedure is also different. Please don’t be concerned if you are taken to the testing area before someone who arrived prior to you. We will strive to provide each patient with the specialized care they deserve which can cause some fluctuations in the amount of time needed for each test. We will be sensitive to the needs of all of our patients - all of the time.

Below is the average amount of time spent in the testing area for the most common procedures:

- Screening Mammograms: 20 minutes
- Diagnostic Mammograms: 60 minutes
- CAT Scans: 30 minutes
- X-Rays: 15 minutes
- MRI: 45 to 60 minutes
- Bone Density Screenings: 15 minutes
- Biopsy: 90 to 120 minutes

Please understand these are average times and could vary.
PATIENT HISTORY FOR CONTRAST MEDIA

Patient Name: ___________________________ Date of birth: _______________ Height: ______
Weight: ______

1 Please indicate if you have one of the following *:
   □ History of "kidney disease" as an adult or family history of kidney problems
   □ History of kidney transplant
   □ History of liver disease
   □ Diabetes
   □ Paraproteinemia syndromes or diseases (e.g. myeloma)
   □ Collagen vascular disease (e.g. Lupus)
   □ Recent contrast study (e.g. within the last 7 days)
   □ Recent surgeries? If yes, please list: ________________________________
   □ Sickle cell disease

Certain medications:
   □ Metformin or metformin-containing drug combinations (Metformin, Avandamet, Glucophage, Glucophage XR, Actoplus Met)
   □ Regular use of nephrotoxic antibiotics, such as aminoglycosides, or non-steroidal anti-inflammatory drugs (e.g. Motrin, Aleve)

* If you checked any of the boxes above, please inform your technologist now. You may require special instructions and further blood test(s) to assess your kidney function prior to receiving intravenous (IV) contrast media.

2. Have you ever had an allergic reaction to intravenous contrast (e.g. iodine, gadolinium)? □ YES □ NO
   If "YES", please describe*: _____________________________________________

   *If "YES", based on your reply, you may require pre-medication prior to receiving IV contrast, no IV contrast, or alternative imaging.

3. Do you have a history of the following medical conditions:
   □ Asthma (if you have active asthma, bronchospasm, or bronchitis requiring treatment, please inform your technologist now)
   □ Cardiac Disease (angina, congestive heart failure, aortic stenosis, hypertension, primary pulmonary hypertension, severe but well compensated cardiomyopathy)
   □ History of allergic (anaphylactic) reaction to one or more allergens

Signed: ___________________________________________ Date: ________ Time: ________
(Patient, Parent or Guardian)

CONTRAST MEDIA PATIENT HISTORY

REV: 07/22/2010
OUTPATIENT QUESTIONNAIRE/ FALLS ASSESSMENT

Please answer the following questions:

Fall Risk Assessment

Yes  No
☐  ☐  Do you feel unsteady when you walk?
☐  ☐  Do you use anything to help you walk?
☐  ☐  Have you had any recent falls or near falls?
☐  ☐  Have you taken any medications today that make you drowsy or dizzy?

What is one thing that I can do for you to make sure that you get very good care today?

__________________________________________________________

Are there any special needs/considerations that we should know about?

__________________________________________________________

__________________________________________________________

Patient Signature ________________________________ Date ________ Time ________

Authorized Representative __________________________ Relationship ________ Date ________ Time ________

FOR STAFF USE ONLY:

☐ Patient is at high risk for falls. (Check if any answer above is ‘Yes’.)

Actions Taken:

☐ Patient given facility specific fall precaution identification.
☐ Escorted Patient under their own power.
☐ Escorted Patient by wheelchair.
☐ Patient used their own cane/walker or other device.
☐ Instructed Patient that a staff member should be present each time they ambulate while in the facility.

STAFF SIGNATURE __________________________ DATE ________ TIME ________
This form must be completed for/by all female patients who have menstruated and could possibly be or become pregnant. Although most standard radiology procedures cause low, non-harmful levels of radiation exposure to a fetus, more specialized procedures that utilize higher radiation doses may pose an increased health risk to a fetus, depending upon the type of procedure, location on the female's body (e.g., pelvis, abdomen), radiation dose, and stage of pregnancy. The following information will help your health care provider assess and discuss with you the risks, benefits, and alternatives of performing or postponing the radiology procedure that has been ordered by your physician or whether a different or limited radiology procedure is available. This form will be retained with your medical records. The information provided by you will be used or disclosed only in accordance with federal or state law.

Name

LAST
FIRST
MIDDLE

Date of Birth: _______ / _______ / _______       Age: _______

Date of Last Menstrual Cycle: ___________________________

1. Are you pregnant?    ☐ Yes       ☐ No       ☐ Maybe
2. Could you be pregnant?  ☐ Yes       ☐ No       ☐ Maybe
3. Are you currently breast feeding?    ☐ Yes       ☐ No
4. Do you have history of a tubal ligation, and/or a hysterectomy and/or menopause?    ☐ Yes       ☐ No

I have read and understood the above information and the above information is correct.

_________________________________________  _______________  _____________
Signature Patient/Legal Representative          Date          Time

_________________________________________
Printed Name Patient/Legal Representative

RAD SCREENING-CHILDBEARING AGE FEMALES

REV: 07/22/2010
IONIZING RADIATION PREGNANCY
CONSENT FOR TREATMENT

Female patients who are pregnant or suspect that they may be pregnant should not have an exam that utilizes ionizing radiation unless the patient's ordering physician determines the exam is medically necessary and the patient consents to the exam after having had the risks, benefits, and alternatives explained. If possible, confirmation of pregnancy/non-pregnancy for females who could possibly be or become pregnant is important prior to performing an ionizing radiological exam. Although most standard ionizing radiation procedures cause low, non-harmful levels of radiation exposure to a fetus, more specialized procedures that utilize higher radiation doses may pose an increased health risk to a fetus, depending on the type of procedure, location on the female's body (e.g., pelvis, abdomen), radiation dose, and stage of pregnancy.

I. UNCLEAR PREGNANCY STATUS (Please check and initial all that apply below)

1. I am unsure of my pregnancy status
   Patient Initials

2. I have decided to delay or reschedule the exam/procedure until my pregnancy status is confirmed. Facility staff will notify my ordering physician of the delay or rescheduling of my exam.
   Patient Initials

3. I am requesting that the facility perform a pregnancy test at my expense.
   Patient Initials

4. I am unsure of my status and have declined a pregnancy test. I have decided to have the exam with ionizing radiation and I understand the risks, benefits, and alternatives involved.
   Patient Initials

By signing below I agree that these statements are true: (a) I've had the opportunity for a physician to discuss the risks, benefits, and alternatives of the ionizing radiation procedure/exam with me, (b) I have had the opportunity to ask questions of the physician, and (c) I hereby release the Baylor Health Care System and this facility from any complications that may occur from my decision to delay, reschedule or undergo the ionizing radiation procedure/exam.

Signature Patient/Legal Representative
Printed Name Patient/Legal Representative
Date
Time

II. POSITIVE PREGNANCY STATUS (Please check and initial all that apply below)

1. I am pregnant or have had a positive pregnancy test, and I have decided to delay or reschedule the exam/procedure until I have had a chance to discuss this exam further with my referring physician.
   Patient Initials

2. I am pregnant and I have consented to undergo the exam with ionizing radiation with the knowledge of the risks, benefits, and alternatives to my unborn fetus and I understand the risks, benefits, and alternatives involved.
   Patient Initials

By signing below I agree that these statements are true: (a) I've had the opportunity for a physician to discuss the risks, benefits, and alternatives of the ionizing radiation procedure/exam with me, (b) I have had the opportunity to ask questions of the physician, and (c) I hereby release the Baylor Health Care System and this facility from any complications that may occur from my decision to delay, reschedule or undergo the ionizing radiation procedure/exam.

Signature Patient/Legal Representative
Printed Name Patient/Legal Representative
Date
Time

CONSENT-IONIZING RADIATION
PREGNANCY

REV: 07/22/2010