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Chelsea and Westminster Hospital NHS
NHS Foundation Trust

Pre-Procedure Checklist for CT Colonography

Checklist	Yes	No	Comments
Use of toilet prior to scan?	Yes	No	
Compliance with bowel preparation	Yes	No	
Allergies	Yes	No	
Asthma / Hayfever	Yes	No	
Kidney problems	Yes	No	
Diabetes - metformin	Yes	No	
Previous IV contrast	Yes	No	Note any reactions
History of Glaucoma	Yes	No	Treated / untreated
Cardiac history Do ***not*** administer Buscopan if: Unstable angina Recent MI/ cardiac problem requiring hospital admission (within 3 months) *Uncontrolled* or suspected arrhythmias	Yes	No	
History of myasthenia gravis?	Yes	No	
Urinary retention problems?	Yes	No	
Appendix removed? When?	Yes	No	
Any colonic / abdominal surgery?	Yes	No	
Other significant medical history?	Yes	No	
Current medications	Yes	No	
Patient information leaflet received and read?	Yes	No	
Verbal advice given around risks of scans and contrast injection?	Yes	No	
Risk of extravasation explained to patient	Yes	No	
Is there a possibility you may be pregnant?	Yes	No	LMP date:
Previous imaging history checked?	Staff initial:		

To be completed by patient

I agree to undergo Virtual Colonoscopy by a suitably experienced member of the team ☐

I agree that my anonymised CT data may be used for teaching/training/research and audit purposes ☐

Patient Signature: ..... Print name: …… Date: …….

☐ Completed on behalf of patient:

Signature: …….. Print name: …….. Date: …….

Please scan this document into Soliton at the end of the CT scan.

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Statement of Health Professional

I have explained the possible reactions to Buscopan and iodinated contrast agents. □

I have explained the small risk (1 in 3000) of perforation and the action that would be taken if this occurs. □

I have explained that this test involves exposure to ionising radiation. □

I have explained the risks of CT colonography including symptoms of bloating and abdominal discomfort. □

Staff signature: …….. Print name: …….. Job title: ……..

Patient ID Confirmed:

Full name ☐ DOB ☐ Address ☐ Wristband ☐

Name ……. Signed ……. Date …….

Cannula inserted or flushed by:

Name …… Signed……

Number of attempts…… Site…..... Cannula size ……..

Renal Function:	Contrast type:	Comments:
Creatinine:……	Batch no/expiry date:	
eGFR:……	Volume:	
Date:……	**Pump filled by:** **Checked by:**	

Radiographers involved in scan: (*denotes who inserted the tube)

Rad 1*: ……..... Rad 2: ……..……

Buscopan: Yes ☐ Lot number: …… Expiry date: ……

No ☐ Please state why: ……

Is distension adequate? If Yes, tick appropriate box for each colonic segment. If No, cross in appropriate box.

Scan 1 (Supine)		**Scan 2**		**Scan 3 (if needed)**	
Rectum	☐	Rectum	☐	Rectum	☐
Rectosigmoid	☐	Rectosigmoid	☐	Rectosigmoid	☐
Sigmoid	☐	Sigmoid	☐	Sigmoid	☐
Descending	☐	Descending	☐	Descending	☐
Splenic Flexure	☐	Splenic Flexure	☐	Splenic Flexure	☐
Transverse	☐	Transverse	☐	Transverse	☐
Hepatic Flexure	☐	Hepatic Flexure	☐	Hepatic Flexure	☐
Ascending	☐	Ascending	☐	Ascending	☐
Caecum	☐	Caecum	☐	Caecum	☐

Litres of CO_2 used: ……

Has chest been imaged? Yes ☐ No ☐

CTC failed/problems encountered? ……