CT SCAN CHECKLIST

NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

PATIENT USE

As part of your CT examination, you may be required to have an injection of an **x-ray contrast** agent (dye). The following questions are to check that it is safe for us to administer this contrast.

Do you have any allergies? (Drugs,food,latex,iodine or other) If yes, please specify …….	Yes	No
Do you suffer from Asthma or Hayfever	Yes	No
Do you suffer from Kidney or Heart disease?	Yes	No
Do you suffer from diabetes? If yes, do you take Glucophage (metformin) tablets?	Yes	No
Do you take any regular medications? If yes, please specify …… ……	Yes	No
Have you had x-ray dye (contrast) in the past?	Yes	No
Did you have any reaction to the contrast injection? ……	Yes	No
Did you receive a patient information leaflet?	Yes	No
Do you agree to have your CT data anonymised so that it may be used for teaching/training/research or audit purposes?	Yes	No
Patients of child bearing age: Is there a possibility you may be pregnant? What was the first day of your last menstrual period? ……	Yes	No

By signing below, you acknowledge that your personal details are correct and you have answered the questions to the best of your knowledge.

Patient signature……

Print name …… **Date** ……

☐ Completed on behalf of patient:

Signature…… Print name …….. Relationship to patient ……..

STAFF USE

Patient Information / Sticker:

Name: …… DOB: ……..

Postcode: …….. MRN: ……..

Examination: ……..

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

Verbal advice given around risks of scans and contrast injection	Yes	No
Risk of extravasation explained to patient	Yes	No
Checklist completed by:		

Scanning Radiographer:
I confirm that the correct departmental patient identification procedures have been followed. I have checked all contraindications as per the imaging department IV policy and checked previous imaging history before proceeding with the scan.

Name …… Signed……Date……

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

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