NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
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Facility: _____

RADIOLOGY PATIENT SAFETY FLOW SHEET – NON-IONIC CONTRAST CT SCAN

Location: _____ **Ext:** _____ **Date:** _____ **Unit:** _____

ID by: _____**,via: Name** ☐ **DOB** ☐ **MR#** ☐ **ID Band IV Contrast Checklist**: ☐ Contrast Required

***History of Kidney problems:** ☐ No ☐ Yes, Describe: _____

BUN _____ CREATININE_____ GFR_____*__**Alert values: Cr greater than or equal to 1.5 and/ or GFR less than 60**

Pre-medications given: ☐ No ☐ Yes, list: _____

*__**Allergies:** ☐ No ☐ Yes, Describe: _____

***Asthma:** ☐ No ☐ Yes, list meds:_____

***Diabetes:** ☐ No ☐ Yes, list meds:_____

***Multiple Myeloma:** ☐ No ☐ Yes

*__**Sickle Cell Disease:** ☐ No ☐ Yes

***Pregnant:** ☐ No ☐ Yes ☐ LMP _____ **Breastfeeding:** ☐ No ☐ Yes

***Has the patient ever experienced a problem during a radiology exam?** ☐ No ☐ Yes, describe:

_____

***If yes, consult with Radiologist required prior to exam.**

Please Complete As Needed

Time	BP	HR/ Pulse	ECG	RR	Pain**	Mental Status***

Additional IV fluids given: ☐ no ☐ yes, ☐ NS ☐ LR ☐ D5W

Total amount:_____

Blood Products given: ☐ no ☐ yes, total: _____

PRBC_____ FFP_____ Platelets_____ PCC____units

****Pain:** **0**=no pain, **10**= severe pain

*****M/S:** **1**=alert **2**=drowsy/cooperative
3=drowsy/uncooperative **4**=unresponsive/self-airway
5=unresponsive/w/o self-airway

Medication Orders
***Do not complete if electronically ordered/prescribed**

☐18 ☐ 20 ☐ 22 gauge ☐ _____ IV Site: _____

☐ Barium Sulfate _____ ml PO at _____

☐ Gastrografin _____ ml PO at _____

☐ Tap Water _____ml PO at _____

☐ Omnipaque _____ml I.V. at _____

☐ Visipaque_____ml I.V. at _____

☐ Saline _____ml I.V. at _____

☐ No Oral Contrast

☐ E-Z Gas II _____gm PO _____

☐ Other _____

☐ Other _____

I have reviewed the patient's current medications

Radiologist/LIP/Designee Signature:

Print:_____Sign_____

Date:_____Time:_____am/pm

Contrast Verification Confirmed: ☐ Correct Patient, Contrast Agent, Dose, and Route Confirmed.

Signature/ Title: _____**Date:**_____ **Time:** _____**am/pm**

Documentation / Patient Teaching:

☐ No adverse effect observed during study.
☐ Patient given verbal instructions to drink 6-8 glasses of water today
☐ Patient advised to report delayed adverse reaction to MD or come to ED
☐ Instruction post-study sheet given to patient ☐ Routine ☐ Diabetic
☐ Breastfeeding to be withheld for 48 hrs after receiving contrast

Notes: _____

Signature/ Title: _____**Date:** _____**Time:** _____**am/pm**

***** Radiologist Signature (only when consult required)** _____**Date:** _____**Time:** _____**am/pm**