DIAGNOSTIC RADIOLOGY ASSOCIATES, LLC
INTRAVENOUS CONTRAST CHECK LIST

Please complete before administering contrast

Patient Name_____Date_____

Exam_____

Does patient have any of the following contrast risk factors?

	YES	NO	UNSURE
Previous contrast reaction	☐	☐	☐
Strong Medication allergy/asthma history	☐	☐	☐
History of Kidney Problems	☐	☐	☐
Hypertensive heart disease w/o CHF	☐	☐	☐
W/CHF	☐	☐	☐
Acute myocardial infarction Coronary occlusion	☐	☐	☐
Intermediate coronary syndrome (preinfarction or unstable angina	☐	☐	☐
Congestive heart failure Cardiomegaly	☐	☐	☐
Sickle cell anemia	☐	☐	☐
Multiple myeloma, polycythemia Or pheochromocytoma	☐	☐	☐
Younger than 6 months old	☐	☐	☐
Known brain tumor or metasases	☐	☐	☐
Taking diabetic medication: (Glucophage, Glucovance)	☐	☐	☐

Last time patient ate or drank_____

If a risk factor is checked yes a radiologists must decide whether to give or withhold contrast.

Signed by _____MD.