RapidSound, Inc / Green Valley Imaging
450 W Continental Rd
Green Valley, AZ 85622

HISTORY & CONSENT FORM

Name: _____ DOB: _____ G- _____

EXAM: _____ DATE: _____

Reason for Exam: _____

_____

_____

Hx: _____

_____

_____

Prior Studies: _____

Surgeries: _____

Do you have allergies to food or Iodine? _____Yes _____No List: _____

Do you have history of Diabetes? _____Yes _____No Do you take Metformin? _____Yes _____No

Do you have history of Renal Disease? _____Yes _____No Dialysis? _____Yes _____No

Do you have history of Renal Cancer? _____Yes _____No Renal surgery/implants/kidney remov _____Yes _____No

Are you on Hypertension Medical Therapy? _____Yes _____No Do you have Asthma? _____Yes _____No

Do you have Bone Marrow Cancer (Multiple Myeloma)? _____Yes _____No

Do you have Collagen Vascular Disease (Lupus or Scleroderma) _____Yes _____No

Do you have allergies to Contrast or X-ray Dye? _____Yes _____No

Type of Reaction: _____ Rash/Hives _____Tightness of Throat _____ Difficulty Breathing _____ Other

Date of Reaction: _____ Treatment received: _____

I understand and have answered the above questions.

_____ _____

Patient Name Verified by

TO BE FILLED OUT BY TECHNOLOGIST

Was Pt pre-medicated today? _____Yes _____No If so list pre-meds & dose: _____

Creatinine Level: _____ Inject by: _____ Dose: CTD/Vol _____

Lot # _____ Expiration date: _____ DLP: _____

Oral Amt: _____ Needle Guage/Site: _____ Flow Rate _____ Optiray 350: _____ml