MANDATORY PATIENT QUESTIONNAIRE FOR CT EXAMINATIONS WITH CONTRAST AGENT

PATIENT IDENTIFICATION:

RX LABEL

PATIENT LABEL / VI STRIP
Last name:
Given name(s):
Date of birth:
Gender: ❑ male / ❑ female

► **WEIGHT:**. ..... **kg**

► Have you already undergone a similar examination with contrast agent?	❑ Yes	❑ No
► Have you ever had an allergic reaction to contrast agent?	❑ Yes	❑ No
► Are you allergic to iodine?	❑ Yes	❑ No
► Do you suffer from allergies and/or take medication for them?	❑ Yes	❑ No
► Do you have a portal catheter (port-a-cath)?	❑ Yes	❑ No
► Do you have a hip prothesis?	❑ Yes	❑ No
► Have you ever smoked?	❑ Yes	❑ No
For how many years?		
How many packs a day?		
► Do you suffer from Kahler's disease?	❑ Yes	❑ No
► Do you have diabetes?	❑ Yes	❑ No
If so, do you take pills for this?	❑ Yes	❑ No
► Do you have a thyroid problem?	❑ Yes	❑ No
► Are your kidneys functioning less effectively?	❑ Yes	❑ No
► Do you have asthma?	❑ Yes	❑ No

► For female patients:

► Are you (possibly) pregnant?	❑ Yes	❑ No
► Are you breastfeeding?	❑ Yes	❑ No

Other relevant additional information:

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This examination is important for determining the next steps in your care. During regular working hours (8AM-6PM; Mon-Fri), we can perform this examination at the standard rates, with the personal responsibility portion equal to the co-payment. Outside these working hours and at weekends, the personal responsibility portion is higher (between €7.00 and €14.00), depending on the type of examination.

Name: ..... Signature:

Date: ..... / ..... / .....