CONTRAST INJECTION SHEET

X-Ray Number ________________________________

Date ________________________________

Patient Name _______________________ Inpatient ( ) Outpatient ( ) ER ( ) Other ( )________________________

Medication: Is the patient taking Glucophage, Glucovance, Metformin or Glipizide? Yes ( ) No ( ) If yes, inform Radiologist prior to injecting Contrast. The patient must be off this medication 48 hrs. after the Injection of Contrast to prevent the possibility of Renal Failure.

Patient Education:
Patient verbalizes understanding of teaching Yes ( ) No ( )

Intra-Assessment
Type of Contrast Administered __________________________ Non-Ionic Bolus ( ) Injector ( ) Amt. Administered _____ cc

Injected via: Existing IV ( ) Saline Lock ( ) Porta Cath ( ) Other ( )________________________

IV Start: Venipuncture Site __________________________ Number of Sticks _____ Angio Cath _____ ga Butterfly _____ ga

Re-Assessment
Contrast Reaction? None ( ) Hives ( ) Nausea & Vomiting ( ) Sneezing ( ) Other __________________

Treatment Given: Adrenalin ( ) Benadryl ( ) Solu Medrol ( ) Other __________________

Amount Given: __________________________

IV Site Complication Post Injection? Yes ( ) No ( ) Tech Initials __________________________