

Rockledge MRI & PET Imaging Center

1910 Rockledge Blvd Suite 102, Rockledge, FL 32955

CT Clinical Information & Contrast Consent Form

Patient Name _____ Age _____ Weight _____

Reason for Exam _____

Prior Surgeries to area being scanned? Yes No If yes, Please list below:

History of Cancer? Yes No

Type _____

Treatment? (Circle) Surgery Chemotherapy Radiation

History of Kidney Failure/Dialysis? Yes No

Are you Diabetic? Yes No Are you taking any Metformin type medication? Yes No

Have you ever had an injection of IV Dye/Iodine? Yes No Reaction Yes No

Allergies? _____

Females Only: Pregnant? Yes No Hysterectomy? Yes No Breastfeeding? Yes No

Prior Studies of area being imaged? Yes No

Where? _____ Year? _____

Creatinine Results _____ Test Date _____

Patient Signature _____ Date _____