

# UNIVERSITY IMAGING

## CT

### You are scheduled for a Computed Tomography (CT) Scan at University Imaging

Thank you for choosing University Imaging. We look forward to serving your medical needs. Please review the following instructions and complete the Patient History Form (located on the back side of this form) prior to your appointment.

**A Computed Tomography (CT) scan** is a diagnostic imaging procedure that uses a combination of X-rays and computer technology to produce vertical and horizontal cross-sectional images (often called slices) of the body. It shows detailed images of any part of the body, including the bones, muscles, fat, organs, and blood vessels. CT scans are more detailed than standard X-rays.

Many of the University Imaging sites utilize low-dose CT scanners. Low-dose CT scanners significantly decrease the level of radiation exposure to the patient while maintaining high image quality.

The CT scan causes no pain.

#### IMPORTANT INFORMATION

You may receive a call from us to review your medical history with you to determine that no issues exist preventing you from having a CT scan. If you need to cancel or reschedule your appointment, please provide 24 hours notice.

If you believe you may be pregnant or have had a contrast allergy/reaction while undergoing a previous imaging study (i.e., hives, rash, breathing difficulty), please call the site where you are scheduled (refer to bottom of page) at least 3 days prior to your scheduled appointment so we may make the appropriate modifications to your treatment plan.

#### Instructions for the day of your scan:

- Remove all jewelry and/or metal.
- Leave valuables at home.
- Bring your insurance card and photo ID.
- Generally, fasting is required prior to administering contrast. You will be (have been) advised of your fasting requirement at the time of scheduling the scan.
- A parent/guardian should remain in the building while a child (under 18 years) is having an imaging procedure.

#### What to expect the day of your CT scan:

- Some CT scans require drinking a flavored oral contrast (barium).
- Some CT scans involve an injection of contrast. Your procedure will be explained to you prior to your scan. If this type of contrast is needed, an IV will be inserted.

#### What to expect after your scan:

- You will be provided with post-procedure instructions.
- Your results will be sent to your referring physician within 2 business days.

**IMPORTANT: Please complete the Patient History Form (located on the back side of this form) PRIOR to your appointment.**

<b>University Imaging at Strong Memorial Hospital</b> 601 Elmwood Avenue Rochester, NY 14642 585-784-2985	<b>University Imaging at Highland Hospital</b> 1000 South Avenue Rochester, NY 14620 585-341-6785	<b>University Imaging at F.F. Thompson Hospital</b> 350 Parrish Street Canandaigua, NY 14424 585-396-6910	<b>University Imaging Science Park</b> 110 Science Parkway Rochester, NY 14620 585-785-5000	<b>University Medical Imaging</b> 4901 Lac de Ville Blvd. Rochester, NY 14618 585-341-9100
Appointment Date/Time:	Appointment Date/Time:	Appointment Date/Time:	Appointment Date/Time:	Appointment Date/Time:



Patient Name: _____
Date of Birth: _____
Procedure Date: _____

**HEALTH HISTORY FORM: Please provide the following information to the best of your knowledge (a parent/guardian should fill out for children under 17 years old):**

- Reason for scan: \_\_\_\_\_
- Allergies:  Medication  Latex products  Contrast dye  No known allergies  
If any allergies, list the reaction: \_\_\_\_\_
- Are you taking **Coumadin (Warfarin)**?  No  Yes
- What operations/surgeries have you had? \_\_\_\_\_  
\_\_\_\_\_
- Do you have any implants?  No  Yes If yes, what type? \_\_\_\_\_

Medication	Dose (mg)	How often?

Medication	Dose (mg)	How often?

- How would you rate your pain? Rating is 0–10 with 10 being the most painful \_\_\_\_\_
- List the parts of your body in pain \_\_\_\_\_
- Are you pregnant?  No  Yes Date of last menstrual period: \_\_\_\_\_
- Have you ever had contrast for an imaging study?  No  Yes If yes, did you have any problems? \_\_\_\_\_
- Have you had a similar imaging study before?  No  Yes If yes, what was the study? \_\_\_\_\_
- Any Problems? \_\_\_\_\_

Are you being/Have you ever been treated for:	No	Yes
Bleeding Problems/Anemia		
Difficulty Breathing/Asthma/Sleep Apnea		
Stomach Problems/Reflux or Stomach ulcers		
Heart Problems		
High Blood Pressure		
Kidney Problems		
Cancer		

Are you being/Have you ever been treated for:	No	Yes	
Liver Problems			
Seizures			
Diabetes			
Neck or Back Pain			Location: _____ _____
Leg Pain			<input type="checkbox"/> Left <input type="checkbox"/> Right
Arm Pain			<input type="checkbox"/> Left <input type="checkbox"/> Right

Current Height: \_\_\_\_\_

Current Weight: \_\_\_\_\_

\_\_\_\_\_  
PATIENT SIGNATURE

\_\_\_\_\_  
PROVIDER(S) REVIEWING FORM

\_\_\_\_\_  
DATE