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 _____