



CT EXAMINATION WORKSHEET

Patient Sticker		Completed by (CT Tech) Name: _____ Signature: _____
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Complete this section for all CT examinations (non-contrast and contrast)

Patient 3 point ID checked – Name/DOB/Address	Yes	No	
Detailed clinical notes available?	Yes	No	
Questionnaire completed and signed (if contrast)	N/A	Yes	No
Tech or Nurse has reviewed patient questionnaire	N/A	Yes	No
Is patient pregnant? (Patient to sign) _____	N/A	Yes	No

Protocol _____

Justified by Radiographer:	Yes	No	Radiographer name: _____
(Generic justification via protocol)			Date Justified: _____

OR

Radiologist	Yes	No	Date/Time: _____
Radiologist – Name, time & instructions			Instructions: _____
Radiologist Name: _____			_____
_____			_____
Date: _____			Date: _____

Complete this section for all CONTRAST CT examinations only

Patient currently takes Metformin	Yes	No	Patient has known renal impairment	Yes	No	eGFR: (if known): _____
			Yes	No	Urea: _____ Create: _____	

CONTRAST LABEL

Date taken: _____

Oral Contrast	Yes		Contrast	Yes		_____ mls
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IV Contrast _____ Venepuncture by _____

Please note that patients taking Metformin may be at increased risk of contrast induced nephropathy

Radiation Dose CTDI _____	mGy
TOTAL DLP _____	MgYM