UNIVERSITY OF VIRGINIA HEALTH SYSTEM

0500004

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

DOWNTIME CONTRAST REACTION REPORTING FORM

Date: _____

Type of Exam - _____ ☐ Inpatient ☐ Outpatient ☐ ER

Contrast Questionnaire completed prior to exam: ☐ Yes ☐ No

Known History of Contrast Reaction

Type of reaction: ☐ Hives ☐ Itching ☐ Difficulty Breathing ☐ Other _____

Approx. time between exposure and occurrence: _____

Premedication taken / time / dose: _____

Unexpected Contrast Reaction

Type of reaction: ☐ Hives ☐ Itching ☐ Difficulty Breathing ☐ Other _____

Time of occurrence: _____ Time between exposure and occurrence: _____

Name / time Radiologist notified: _____ Nurse:_____

Contrast Type / Amount: _____ Lot Number: _____

Pt. disposition: _____

Patient given written Post Contrast instructions: ☐ Yes ☐ No

Patient demonstrates understanding: ☐ Yes ☐ No

Phone number where pt. can be reached: _____

☐ *Sent form to Radiology Nursing for follow-up call and documentation in EMR.*

Follow-up call (usually 24 hours post-reaction) done by _____ RN on _____

and the patients condition is _____

Additional Comments: _____

_____

_____

_____

Check appropriate box		
History of contrast reaction	☐ Yes	☐ No
Documented in EMR:		

Name _____

Signature _____ Date _____

Completed form sent to HIS. Copies to EMTLA log and CT Supervisor.