



**DIAGNOSTIC IMAGING ASSOCIATES
CORONARY CT ANGIOGRAPHY**

PART I: TO BE COMPLETED BY SCHEDULING PERSONNEL

Patient Name: _____

Date of Patient Call: _____

DIA Scheduler: _____

Date of Scheduled CTA: _____

- Is the patient currently taking a Beta-Blocker, Amiodarone, Verapamil or Diltiazem?** Yes No
 - If YES, the patient can be scheduled for the CCTA. Instruct patient to take existing prescribed medications as usual on the day of study. If YES, proceed to Question 3.
 - If NO, proceed to Question 2.

- Does the patient have any known contraindications to taking a Beta-Blocker?**

asthma, emphysema or COPD	<input type="checkbox"/> Yes	<input type="checkbox"/> No
active congestive heart failure - a.k.a. "wet lungs"	<input type="checkbox"/> Yes	<input type="checkbox"/> No
allergy to Metoprolol or Beta-Blockers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
second or third-degree heart block	<input type="checkbox"/> Yes	<input type="checkbox"/> No
severe sinus bradycardia (heart rate <50)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

NOTE: If patient answers "YES" to any of the above, the study cannot be scheduled until the ordering physician discusses it further with a DIA radiologist.

- Does patient have history of previous cardiac surgery?** Yes No
If YES, where? _____
- Is the patient allergic to IV contrast?** Yes No
- Is the patient a diabetic?** Yes No
- If YES, does the patient take Metformin (Glucophage)?** Yes No
- Does the patient have renal insufficiency?** Yes No
- What was the patient's last BUN and Creatinine?** _____

NOTE: If the person calling to schedule the CT is not a Nurse, PA or Physician, the DIA Scheduling Personnel may need to ask for a health care professional to answer the above questions.

If the patient is not on a Beta-Blocker, Verapamil, Diltiazem or Amiodarone and there are no contraindications to taking a beta blocker, arrange for the patient to receive Metoprolol orally one hour prior to the test (patient should arrive one hour early for study and take after arriving at DIA office). The medication can be obtained from the ordering physician.

PART III: TO BE COMPLETED BY TECHNOLOGIST (PART II on Reverse)

Heart Rate
 Heart Rate at Rest: _____ Heart Rate at Injection: _____
 Blood Pressure: _____ Pulse: _____
 Total Beta Blocker Taken: _____

Scan Locations
 Imaging Bolus Location: _____ Aortic Root (Area of Lt. Main Takeoff)
 End Location: _____ (2cm Below PDA)
 Start Location: _____ (2cm Above Monitor Location)
 Length of Scan: _____ (15cm Max is Optional)

Timing Steps
 No. of Tick Marks to Peak: _____ x2
 _____ sec.
 3 sec. _____ Injection Prep Delay
 3 sec. _____ Buffer
 _____ Total Scan Delay

Injection
 _____ cc per second
 _____ Total Contrast Given



PART II: PATIENT HISTORY FORM

Date: _____ Height: _____ Weight: _____ Sex (M/F): _____

Name: _____ Age: _____ D.O.B. _____

Address: _____

City, State, Zip: _____ Phone: _____

Family Doctor: _____ Phone: _____

Personal Medical History

Please Circle

Possibility of being pregnant Y N

Last Menstruation _____

Stroke or Mini-Stroke (TIA) Y N

Heart Disease Y N

Atrial Fibrillation Y N

Other Vascular Disease Y N

Chest Pain Y N

Persistent Cough Y N

High Blood Pressure Y N

High Cholesterol Y N

History of Alcoholism Y N

Smoker Y N

No. packs per day: _____ No. of Years: _____

Cancer Y N

Type: _____

Diabetes Y N

Osteoporosis _____

Surgery Y N

Type and Date of Surgery: _____

Type and Date of Surgery: _____

Previous Heart Screening Test Y N

When: _____ Where: _____

Family Medical History

Please Circle

Stroke or Mini-Stroke Y N

Heart Disease Y N

Cancer Y N

Type: _____

Diabetes Y N

Osteoporosis Y N

Aneurysm Y N

Where? _____

Gangrene Y N

Father Age _____

Deceased, Age _____

Cause of Death _____

Mother Age _____

Deceased, Age _____

Cause of Death _____

List Current Medications:
