



# REAGAN DIAGNOSTICS

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## CARDIAC VCT PRESCREENING ASSESSMENT

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

(Cannot exceed 500lbs)

DX/Reason for test: \_\_\_\_\_ MD ordering test: \_\_\_\_\_

### History of:

- |   |   |                                 |   |
|---|---|---------------------------------|---|
| Contrast Allergy  | <input type="checkbox"/> Y <input type="checkbox"/> N | Sickle Cell                     | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Coronary Bypass Surgery                                       | <input type="checkbox"/> Y <input type="checkbox"/> N | Stroke                          | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Carotid Endarterectomy  | <input type="checkbox"/> Y <input type="checkbox"/> N | Smoking                         | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Chronic PVC's/PAC's   | <input type="checkbox"/> Y <input type="checkbox"/> N | Hypertension                    | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cardiac Stents  | <input type="checkbox"/> Y <input type="checkbox"/> N | Family History of Heart Disease | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Cancer  | <input type="checkbox"/> Y <input type="checkbox"/> N | Currently on Chemotherapy       | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Heart Catheterization   | <input type="checkbox"/> Y <input type="checkbox"/> N | When _____ Where _____          |   |
| Can you lie flat for 10 minutes with your arms over your head | <input type="checkbox"/> Y <input type="checkbox"/> N |                                 |   |

### Have you been told that you have/are:

- |                      |   |                         |   |
|----------------------|---|-------------------------|---|
| Asthma or COPD       | <input type="checkbox"/> Y <input type="checkbox"/> N | Kidney or renal disease | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Atrial Fib           | <input type="checkbox"/> Y <input type="checkbox"/> N | Diabetes                | <input type="checkbox"/> Y <input type="checkbox"/> N |
| Irregular Heart Rate | <input type="checkbox"/> Y <input type="checkbox"/> N | Currently Pregnant      | <input type="checkbox"/> Y <input type="checkbox"/> N |

If yes to any of the above, call a Physician for follow-up. Contraindications to exam include: Atrial Fib, pregnancy, severe renal disease, severe asthma or COPD

### Contraindications to beta blockers:

- Medically managed asthmatic
- History of COPD
- Bronchospasm
- Allergy to beta blockers
- 2<sup>nd</sup> or 3<sup>rd</sup> degree heart block without pacemaker
- Acute decompensated heart failure
- Systolic BP<90
- Intolerance by history

Current Medications: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Creatinine result: \_\_\_\_\_ Date \_\_\_\_\_ BP: \_\_\_\_\_ HR: \_\_\_\_\_

If creatinine >1.6 contact Physician for orders. If not done within past 30 days, Obtain creatinine if: >60 years of age

MEDS:	Instructions	Yes	No	N/A
Metoprolol Tartrate	50mg morning of and 50mg 1 hour before test. Hold if HR<60 or currently on a beta blocker			

- Patient has received contrast within last 30 days
- Patient has a history of renal disease
- Patient is a diabetic

### Remind Patient:

- No caffeine 12 hours prior to scan (coffee, tea, cola, chocolate).
- Clear liquid diet 4-8 hours prior to scan.
- If they take Viagra, Cialis or Levitra avoid this medication for 48 hours prior to scan.
- Take daily medications as ordered by their physician.
- Do not take Glucophage, Glucophage XR, Metaglip, Avandamet, Metformin, or Glucovance on the day of the VCT.
- Do not use tobacco products 6 hours prior to the scan.

Patients signature below indicates receipt of a copy of this document, that explanation of follow-up instructions has been provided, and that those instructions are understood.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Interviewer signature and title: \_\_\_\_\_