Trinitas Diagnostic Imaging
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**Contrast Assessment**

If you're coming to our center for an MRI or CT test, print this page, fill out the form and bring it in with you on the day of your appointment.

FIRST NAME

LAST NAME

AGE WEIGHT DATE

LMP  [ ] Inpatient  [ ] Outpatient  [ ] Emergency Center

Exam Ordered:  [ ] CT  [ ] IVP  [ ] MRI (please check one)

Have you had this test or other x-ray tests requiring an injection of IV Contrast before?

[ ] YES  [ ] NO

If yes, did you have a reaction to the injection?

[ ] YES  [ ] NO

Describe the reaction

Do you have any allergies to medications?

[ ] YES  [ ] NO

List

Do you have:

Diabetes  [ ] YES  [ ] NO  Blood Disorders  [ ] YES  [ ] NO
Insulin  ☐ YES ☐ NO  Kidney Disease  ☐ YES ☐ NO
Glucophage  ☐ YES ☐ NO  Other Medical Conditions  ☐ YES ☐ NO
Asthma  ☐ YES ☐ NO

Please describe other medical conditions:

Have you had any previous surgery, chemotherapy or radiation therapy?

Date

Procedure Done

Date

Procedure Done

Date

Procedure Done