# heartsure

CT Coronary Angiogram
Patient Questionnaire & Consent Form

Patient Name: ______________________________ Date of Birth: ______/______/________

Patient ID: ______________________________ Height: __________cm Weight: ____________kg

The radiology department has received a request for you to have a CT Cardiac Angiogram. This scan involves the use of X-Rays to examine the arteries that supply the heart muscles and will require you to have an intravenous (IV) injection of contrast media (X-ray dye).

This contrast will allow the Consultant Radiologist to give a detailed report on all your anatomy covered in the scan. The contrast is given through a small tube (cannula) placed into a vein, usually on the inside of the elbow or on your wrist or back of hand or if appropriate through your PICC line. Contrast media is considered quite safe; however, any injection carries a slight risk such as infection or injury to a nerve, vein or artery. It is possible to have bruising or swelling at the injection site after the test.

A rare but possible risk is for the contrast to leak or be injected into tissue. This is called extravasation and if this occurs, we will evaluate and treat the extravasation. If the extravasation is large, the radiologist may request that you go to the Accident and Emergency department for further evaluation and treatment of the swelling and circulation of the affected extremity. Occasionally, a patient will have a mild reaction to the contrast and develop sneezing and/or hives. Uncommonly, more serious reactions have been known to occur. These serious reactions are very rare. Our Radiology team will further explain this to you before your scan. It is important that you complete the following information prior to your scan to help determine your suitability for the contrast injection.

**Please hand over the completed form to the CT Radiographer at the time of your scan.**

Have you ever been told by a health care practitioner that you have the following?

| | | | |
|---|---|---|---|
| a. | Hypertension (high blood pressure) | ☐ No | ☐ Yes |
| b. | High Cholesterol | ☐ No | ☐ Yes |
| c. | A heart valve problem | ☐ No | ☐ Yes |
| d. | A heart murmur | ☐ No | ☐ Yes |
| e. | An Arrhythmia | ☐ No | ☐ Yes |
| f. | Atrial Fibrillation or Flutter | ☐ No | ☐ Yes |
| g. | Heart Failure | ☐ No | ☐ Yes |
| h. | Previous Stroke or TIA | ☐ No | ☐ Yes |

Do you have a family history of heart disease? ☐ No ☐ Yes

If yes, please give details: ______________________________

Do you, or have you ever smoked? ☐ No ☐ Yes

If yes, how many per day, on average? ______________________________

If you've stopped smoking, how many years did you smoke? ______________________________

Are you diabetic? ☐ No ☐ Yes

If so, are you taking Metformin? ☐ No ☐ Yes

Have you had any caffeinated beverages, foods or medicines? (Including fizzy drinks, energy drinks, coffee, decaf coffee, tea, chocolate, cocoa, etc) within the last 12 hours? ☐ No ☐ Yes

If yes, please specify: ______________________________

Have you used the following in the last 48 hours? ☐ No ☐ Yes

Sildenafil (**Viagra**), Tadalafil (**Cialis**), Vardenafil (**Levitra**), Avanafil (**Staxyn**) or similar

Have you had a CT scan before? ☐ No ☐ Yes

Have you had IV Contrast (X-ray dye) before? ☐ No ☐ Yes

If yes, did you experience any problems? ☐ No ☐ Yes

Describe the problem if any: ______________________________

| | | |
|---|---|---|
| Do you have any allergies? | ☐ No | ☐ Yes |

If yes, what to? ______________________________

| | | |
|---|---|---|
| Do you have Asthma? (Please bring your inhalers if so) | ☐ No | ☐ Yes |
| Do you have Hyperthyroidism? | ☐ No | ☐ Yes |
| Are you receiving Therapeutic radio-iodine thyroid treatment? | ☐ No | ☐ Yes |
| Do you have any Kidney Problems? | ☐ No | ☐ Yes |

If yes, please give details: ______________________________

| | | |
|---|---|---|
| Are you on Interleukin II Therapy? | ☐ No | ☐ Yes |
| Do you give consent for the use of contrast using the procedure? | ☐ No | ☐ Yes |

---

**Female Patients between the ages of 12 – 55 years only:**

| | | |
|---|---|---|
| Are you pregnant? | ☐ No | ☐ Yes |

Do any of the following apply?

☐ Hysterectomy ☐ Menopausal ☐ Taking birth control ☐ Not sexually active

Or when was the first day of your menstrual period? ______________________________

I confirm that there is no possibility of pregnancy: ______________________________
Patient signature

---

**PLEASE NOTE**: We may send the acquired data for further analysis to help improve diagnosis and patient management. HeartFlow FFRCT Analysis is a non-invasive diagnostic tool that aids clinicians in determining, vessel by vessel, both the extent of an artery's narrowing and the impact that the narrowing has on blood flow to the heart. All information will be anonymised before being sent off.

| | | |
|---|---|---|
| I understand that the information collected about me may be sent out for further analysis. | ☐ No | ☐ Yes |
| I give my consent for the Radiology Department at Kingston Hospital to send my scan to HeartFlow for further analysis | ☐ No | ☐ Yes |
| I have read and understood the information above and I believe I have provided answers correctly and to the best of my knowledge. I confirm I am the patient or am authorised to act on their behalf and I consent to the above investigation taking place. | ☐ No | ☐ Yes |

Print Name: ______________________________ ☐ Patient ☐ Guardian

Signed: ______________________________ Date: _____/_____/_______

***Radiology Use Only**: Form checked by: ______________________________ Date: _____/_____/_______*