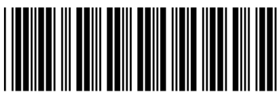
ST. JOSEPH'S
UNITY HEALTH TORONTO



CORONARY ARTERY CT MEDICAL SCREENING FORM

TRANSCRIBED BY (sign, designation, date & time 24 h):	VERIFIED BY (sign, designation, date & time 24 h):

Absolute Contraindications to Coronary CT
(Affirmative response *excludes* patient)

Atrial Fibrilation	☐ Yes	☐ No
Ventricular Bigeminy/Trigeminy	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No

Contraindications to Beta Blockers and Calcium Channel Blockers
(Affirmative responses *do not necessarily* exclude patient)Presently on beta blockers, calcium channel blockers or digoxin? ☐ Yes ☐ No
If yes, specify drug, dose and patient's resting heart rate
____

Asthma ☐ Yes ☐ No
Specify treatment: ___________________________________

COPD ☐ Yes ☐ No
Specify treatment: ___________________________________

Heart Block ☐ Yes ☐ No

Specify treatment: ___________________________________

Heart Failure ☐ Yes ☐ No
- If yes, specify Right or Left: ___________________________
- If yes, specify LV grade or EF: ___________________________

Pulmonary Arterial Hypertension ☐ Yes ☐ No

Systolic Blod Pressure < 90 mmHg ☐ Yes ☐ No

Pre-excitation Syndrome (eg. Wolf-Parkinson-White) ☐ Yes ☐ No

Sick Sinus Syndrome ☐ Yes ☐ No

Are you aware of any reason not listed above that this patient should not receive beta blockers or calcium channel blockers? ☐ Yes ☐ No
If yes, please specify:
____

DATE	TIME (24 h)	SIGNATURE	PRINT NAME
DD/ Month/YYYY	_ _ : _ _ h		

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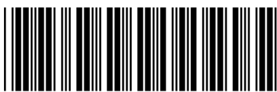

CORONARY ARTERY CT MEDICAL SCREENING FORM

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Contraindications to Nitrates

(Affirmative responses *do not* exclude patient)

On medication for erectile dysfunction (e.g. Viagra)	☐ Yes	☐ No
On nitrates If yes, specify dose: ____	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No
Severe anemia	☐ Yes	☐ No
Increased intracranial pressure	☐ Yes	☐ No
Severe aortic valvar stenosis	☐ Yes	☐ No
Hypertrophic Cardiomyopathy	☐ Yes	☐ No
Recent Myocardial Infarction (< 1 month)	☐ Yes	☐ No
Are you aware of any reason not listed above If yes, please specify: ____	☐ Yes	☐ No

Cardiac History

Previous MI Specify Location, if known ______________________________________	☐ Yes	☐ No
Previous CABG Specify grafts, if known ____	☐ Yes	☐ No
Previous Stent Specify vessels, if known ____	☐ Yes	☐ No

Iodinated Contrast Screening

Does the patient have allergies to iodinated Contrast Media?	☐ Yes	☐ No

If Yes, Pre-medication Instructions for Allergic Patients:

- Prednisone 50mg P.O. 13hrs, 7hrs and 1hr pre-CT exam.
- Benadryl 50mg P.O. 1hr pre-CT exam.

Benadryl can cause drowsiness. These patients should make arrangements to and from the examination.

DATE	TIME (24 h)	SIGNATURE	PRINT NAME
DD/ Month/YYYY	_ _ : _ _ h		

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CORONARY ARTERY CT MEDICAL SCREENING FORM

TRANSCRIBED BY (sign, designation, date & time 24 h):	VERIFIED BY (sign, designation, date & time 24 h):

DI Department Use Only:

Check-in: Time: HR: BP:

Has patient had caffeine in last 12 hours? ☐ Yes ☐ No

Has patient smoked in last 2 hours? ☐ Yes ☐ No

Medication:
Circle which applies:
Metoprolol 100 mg po x 1 dose
Verapamil 240 mg po x 1 dose
Other:

Radiologist Signature:____

Time given:_____________

Post-Medication: Time: HR: BP:
Additional Medications (dose and time given):

DATE	TIME (24 h)	SIGNATURE	PRINT NAME
DD/ Month/YYYY	_ _ : _ _ h		