



RADIOLOGY ASSOCIATES of HARTFORD, P.C.

Avon • 35 Nod Road
Enfield • 9 Cranbrook Blvd
Glastonbury • 31 Sycamore Street

Phone: (860) 969-6400

Fax: (860) 714-8808

Medication Reconciliation

Patient Name: _____ D.O.B.: _____ [] Male [] Female

Exam: _____ Today's Date: _____ Medical Record#: _____

DO YOU TAKE ANY OF THE FOLLOWING MEDICATIONS?

- [] Glucophage [] Fortamet [] Glumetza [] Metformin [] Kombiglyze
[] Glucophage XR [] Riomet [] Actoplus Met [] Avandamet [] Jentadueto
[] Glucovance [] Janumet [] Prandimet [] Metglip

MEDICATION PROFILE

List all medications you have taken prior to your exam today including prescriptions, OTC, herbals, inhalers and supplements.

Table with 4 columns: Medication/Supplement, Dose, Frequency (please check box), Last Dose-Date/Time. Frequency sub-columns: 1x Daily, 2x Daily, 3x Daily, Other.

PLEASE "CHECK" THE FOLLOWING QUESTIONS

- Are you allergic to any medications? [] Yes [] No
Have you had IV Contrast before? [] Yes [] No
Do you have a history of kidney (renal) disease? [] Yes [] No
Do you have a history of cardiac disease? [] Yes [] No
Is there any chance you are pregnant? [] Yes [] No
Are you allergic to any food products? [] Yes [] No
Are you breastfeeding? [] Yes [] No
Have you had anything to eat/drink within the last 4 hours? [] Yes [] No
Do you have a fever or asthma? [] Yes [] No
LMP: _____

I certify that I have read and understood the questions asked in this questionnaire and that the above responses are correct to the best of my knowledge. I understand that I may receive an intravenous injection depending on the exam requested by my referring physician.

Patient Signature: _____ Date: _____

Technologist Signature: _____ Date/Time: _____

ATTENTION: Diabetic Patients

If you are taking any medication containing METFORMIN for the treatment of diabetes (common examples are: Glucophage, Glucophage XR, Glucovance, Fortamet, Riomet, Janumet, Glumetza, Actoplus Met, Prandimet, Metformin, Avandamet, Metaglip, Kombiglyze, Jentadueto), please contact your physician BEFORE taking your next dose of diabetic medication. Please contact your prescribing Physician to inform him/her that you received _____ millimeters of non-ionic contrast for your Radiology procedure. Your physician may have special instructions for you to follow prior to taking your next dose of this diabetic medication.

- [] As a result of your visit, there are no changes to your medications.
[] As a result of your visit, make the following changes _____

Technologist/MD Signature _____