Musculoskeletal Institute of Louisiana

Orthopedic Specialists of Louisiana • Pain Care Consultants

CONTRAST APPROVAL/DISAPPROVAL FORM

Date _____

Patient Name _____ DOB _____

Age_____ Weight_____

BUN_____ Creatinine_____ GFR_____

History of: ☐ Diabetes Mellitus ☐ Hypertension requiring Medical Therapy
History of Renal Disease: ☐ Dialysis ☐ Kidney Transplant ☐ Kidney Cancer ☐ Single Kidney

Current Medications _____

_____

Exam Ordered _____

Exam Date _____ Ordering Physician _____

_____

_____ This GFR value is normal.

_____ This GFR value indicates **MILD/MODERATE/SEVERE** renal insufficiency according to ACR guidelines. This is relative contraindication to Gadolinium contrast administration.

For Abnormal GFR Values ONLY:

Based on ACR's recommendations:

_____ I will cancel the contrast administration.

_____ I want to proceed with the contrast administration. My rationale for continuing contrast administration is_____

_____

_____

_____ _____

Ordering Physician Date