



PLEASE ATTACH PATIENT LABEL OR PROVIDE:

NAME _____

MRN _____ FIN _____

INTERVENTIONAL RADIOLOGY CONTRAST RECORD

DATE: _____ PROCEDURE: _____

BUN: _____ CREAT: _____

INSERTION SITE #1: _____ TIME: _____

INSERTION SITE #2: _____ TIME: _____

INSERTION SITE #3: _____ TIME: _____

CONTRAST USED: _____

	INJECTION TIME	RUN AMOUNT (in mL)		RUN TIME (in sec)	RUN PRESSURE (in PSI)	RUN TOTAL (in mL)	TOTAL (in mL)
RUN #1			FOR				
RUN #2			FOR				
RUN #3			FOR				
RUN #4			FOR				
RUN #5			FOR				
RUN #6			FOR				
RUN #7			FOR				
RUN #8			FOR				
RUN #9			FOR				
RUN #10			FOR				

*IF NO RUN AMOUNT, RUN TIME OR RUN PRESSURE LISTED, INDICATES A HAND INJECTION BY PROVIDER

NURSE SIGNATURE: _____