

**Inpatient Stamper:**

**Exam:** \_\_\_\_\_ **Completed** **Date:** \_\_\_\_\_ **Time:** \_\_\_\_\_

**Contrast Administered:** \_\_\_\_\_ **Yes** \_\_\_\_\_ **No** (If yes, please note the volume)

**Visipaque 270 Volume:** \_\_\_\_\_ **Optiray 320 Volume:** \_\_\_\_\_

**Technologist/ RN Signature:** \_\_\_\_\_