



Open MRI | 64 Slice CT Nuc Med
Ultrasound | X-Ray

(For Cat Scan)

INTRAVENOUS (IN VEIN) CONTRAST STUDY CONSENT FORM

Patient Name: _____

You have the right, as a patient, to be informed of the risks and hazards involved with a diagnostic procedure(s). This disclosure is not meant to frighten or alarm you. It is simply an effort to make you better informed so you may give or withhold your consent to the procedure. Your doctor has requested a/an _____, which requires the administration of an iodine-containing compound (contrast) and/or gadolinium. A small percentage of patients may develop a reaction to a contrast injection. Symptoms such as a metallic taste, warm sensation all over the body, nausea, and rarely vomiting are usually transient and generally do not require any treatment.

“Minor” reactions such as sneezing, red eyes, runny nose, and itching indicate mild allergic reaction and are generally not life threatening. Swollen tongue, difficulty in breathing, generalized urticaria, shock, etc... indicate “Major” reactions, which are serious and may be life threatening and require treatment. The risk of developing “Major” reaction is much less if you had no problems with contrast injections in the past. Inform the radiologist of previous allergic reaction(s).

Have you previously had Iodinated Contrast? YES NO If yes, did you have any side effects? _____

Are you on Dialysis? YES NO If yes, when is your next dialysis appointment? _____

Have you recently taken any blood thinning medication? YES NO

Do you have a history of any of the following? Please circle YES or NO.

- | | | | | | |
|-----|----|--------------------------|-----|----|--|
| YES | NO | Kidney Problems | YES | NO | Pheochromocytoma |
| YES | NO | Allergies to Medication | YES | NO | Hemolytic Anemia |
| YES | NO | Severe Allergic Reaction | YES | NO | Diabetes |
| YES | NO | Latex Allergy | YES | NO | If diabetic, do you take Glucophage or Generic |
| YES | NO | Multiple Myeloma | YES | NO | Asthma, if yes explain: _____ |
| YES | NO | Sickle Cell Disease | | | |

I am aware of the possibilities and accept all responsibility for any such reaction(s) and consequences. I will not hold Advanced Diagnostics; it’s physicians, contractors, or personnel responsible for any such reaction(s).

Patient Signature: _____ Date: _____

Witnessed: _____ Date: _____

Laboratory results and date: _____ BUN: _____ Creatinine: _____ Quantity and type of contrast used: _____ Time of Injection: _____ Patient history: _____ Technologist’s Signature: _____ Date: _____
--