LABEL

Consent for Iodinated Contrast Injection

EXPLANATION OF CT EXAM WITH IV CONTRAST

- Your physician has referred you for a CT scan. The scan involves the injection of an iodine contrast.
- The contrast circulates through your body and helps us to visualize internal organs.

POSSIBLE SIDE EFFECTS - MILD

- During the injection you may experience a warm sensation or a metallic taste that will fade over several minutes. There might be a slight chance of nausea or vomiting.
- Anytime an injection is given there is a risk of bruising, redness or swelling at the site of injection.
- Rarely there is an injection leak of the vein and painful blisters can result.
- Infrequently, you may experience a mild allergic reaction to the contrast like itching, hives, sneezing, swelling of the lips and eyes or wheezing. We have medication at hand to treat these conditions if necessary. It is very important that you inform the technologists if you experience any discomfort.

POSSIBLE SIDE EFFECTS – MODERATE TO SEVERE

- Rarely a more serious reaction may occur like shortness of breath, chest pain, irregular heartbeat, kidney failure, and shock or tissue damage at the site of injection.
- Few patients may develop anaphylactic reaction to the contrast although very rare. Should these occur, appropriate treatment can be provided without difficulty. The risk of death is 1 out of 100,000 exams.

POTENTIAL BENEFITS

- The risk of threatening side effects, while real, is far less than the risks associated with not making the correct diagnosis or the risks associated with a delay in diagnosis. Your physician can use the information derived from this study to better manage your care.

FEMALE PATIENTS

- CT scans also involve radiation which may be harmful for the fetus or newborn.
- If there is any possibility that you may be pregnant or breast feeding at this time, please inform the radiology technologist prior to the exam.

QUESTIONS

- You have been told the risks, benefits and alternatives to this procedure.
- You have an opportunity to ask questions regarding your exam.

PATIENT HISTORY

Have you ever had a reaction to any contrast material?	Yes	No	Explain: ______
Do you have any history of asthma? If yes, is it stable?	Yes	No	Explain: ______
Do you have any allergies to food or medications?	Yes	No	Explain: ______
Do you have any heart conditions?	Yes	No	
Are you diabetic?	Yes	No	
Are you taking oral medication containing Metformin or Glucophage?	Yes	No	Explain: ______
Do you have any kidney conditions?	Yes	No	Explain: ______
Do you have sickle cell anemia or multiple myeloma?	Yes	No	
Have you had any surgeries to the affected area?	Yes	No	Explain: ______

******If yes to any of the above consult the radiologist******

I have been advised of the nature and purpose of the I.V. contrast procedure, as well as the risks involved or possible complications. Furthermore, I am aware that a physician is available to discuss any alternative method of evaluation. I realize that declining to have this I.V. contrast procedure performed may have negative consequences such as delayed diagnosis or treatment.

I HAVE BEEN ADVISED AND I UNDERSTAND THE ABOVE AND GIVE MY CONSENT TO HAVE THIS I.V. CONTRAST PROCEDURE PERFORMED.

______ Patient/Parent/Legal Guardian Signature ______ Relationship to Patient ______ Date

I HAVE BEEN ADVISED AND I UNDERSTAND THE ABOVE AND DO NOT GIVE MY CONSENT TO HAVE THIS I.V. CONTRAST PROCEDURE PERFORMED.

______ Patient/Parent/Legal Guardian Signature ______ Relationship to Patient ______ Date

Contrast Used:
Ultravist 300 370 Exp. Date: ______

Amount Administered: ______mL

IV Type/guage: ______

IV Site:
Right ☐ Left ☐ IV Type: ______

______
Technologists Signature

PATIENT HISTORY

Patient label

Height: ____________________ Weight: __________________

Reason for Study:

____

Have you had recent imaging procedures for these symptoms such as X-Ray, CT or MRI of the affected area? ☐YES ☐NO **If YES, Please list date & location below.**

____

Are you providing prior films or images on CD? ☐**YES** ☐**NO**

For Female Patients –

Is there a chance you are pregnant?☐YES ☐NO Breastfeeding?☐YES ☐NO

Date of last menstrual cycle: ________________________

Post menopausal or Hysterectomy ☐YES ☐NO

Would you like us to send a copy of your exam report to your Primary Care Physician? ☐No ☐Yes fax to Dr. ___________________ ___________________.

First and last name please

Check all that applies to you:

- ☐ Lump or Mass, Biopsy
- ☐ Cancer
- ☐ Radiation Therapy
- ☐ Chemotherapy
- ☐ Surgery
- ☐ Infection
- ☐ Injury or Accident
- ☐ Seizure
- ☐ Stroke
- ☐ Multiple Sclerosis
- ☐ Sports Related Injury

ALLERGIES: ____

Patient Signature _________________________________ **Date** ________

Technologist Use Only

Tech ________________ Date ___________ Labs Needed? ☐YES ☐NO

IF yes ☐Outside Labs dated _____ ☐ Sun Radiology Piccolo BUN___ Creat ___

Contrast Type _______________ How administered _______________ Amount ____________

Contrast Reaction? ☐YES ☐NO If Yes explain ______________________________

Tech Notes

____

____

Tech Signature ____