PremiereScan
MEDICAL IMAGING SPECIALISTS

CT CONTRAST CONSENT FORM

PATIENT NAME: _____

DOB: _____ **MRN:** _____

INFORMED CONSENT FOR INTRAVENOUS INJECTION OF CONTRAST MATERIAL

Your physician has referred you to us for a study that involves the injection of an iodine containing contrast into a vein. The liquid circulates through your body and helps us to visualize some if its internal structures.

During the injection, you may experience a warm sensation that will fade over several minutes. Much less frequently, you may experience transient nausea or even vomiting.

Infrequently, you may experience a mild allergic type reaction with itching and hives. Other allergic type symptoms such a localized swelling of the eyes and lips, or difficulty in breathing may occur. We have medication at hand to treat these conditions if necessary.

Rarely, if the injection leaks of the vein, painful blisters can result. More serious complications include heart and lung problems. Your physician is aware of the remote possibility of these complications and feels that the diagnostic information to be obtained outweighs the risk.

If there is any possibility of your being pregnant, please inform the Radiologic Technologist prior to the x-ray procedure. The physician or Radiologic Technologist will be pleased to answer any specific questions about the procedure before or at the time of the study.

1. HAVE YOU HAD X-RAY CONTRAST IN THE LAST 24 HOURS?	YES	NO
2. ARE YOU DIABETIC?	YES	NO
3. IF YES, DO YOU TAKE GLUCOPAHGE (a.k.a. Metformin)?	YES	NO
4. IF YES, **DO NOT TAKE** THE GLUCOPHAGE UNTIL 48 HOURS AFTER THE CT SCAN.		
5. HAVE YOU EVER HAD A PREVIOUS ALLERGIC REACTION TO X-RAY CONTRAST MATERIAL?	YES	NO
6. IF YOU HAVE A HISTORY OF ASTHMA, HAVE YOU HAD WORSENING SEVERE ASTHMA SYMPTOMS WITHIN THE LAST WEEK?	YES	NO

I, _____, acknowledge in signing this consent for an INTRAVENOUS INJECTION OF CONTRAST MATERIAL, that I have read and understand the preceding explanation.

_____

Signature of Patient | Date/Time | Signature of Witness

If patient is a minor or is unable to sign:

_____

Signature of Patient or Legal Guardian | Date/Time | Signature of Witness

DENIAL OF CONSENT: I have decided not to have this test. My physician has explained to me the possible risks of NOT having this examination.

_____

Signature of Patient | Date/Time | Signature of Witness