Dear Patient:

Your doctor has requested an examination that requires the injection of contrast media in a vein in your arm. This will enable us to image specific internal structures of the body. The contrast may cause you to feel sensations such as a “metallic” taste in the mouth, coolness in arm, a general warmth, or nausea. These sensations are normal and will pass within a couple of minutes, or you may not feel them at all. A few patients experience allergic type reactions to the contrast, usually in the form of hives or itching. In rare cases, death has resulted. Since fatal reactions are so rare, it is difficult to quote accurate numbers, but it has been estimated to occur in less than 1 in 100,000 examinations. Your doctor is professionally knowledgeable of the procedure and the risks, and is recommending that you have the examination. Serious reactions to the contrast media are not common. Our doctors will be willing to answer any questions concerning the procedure.

Consent:

I, ______________________________________________, hereby consent to the following procedure(s), ________________________________________________________________, to be performed by Radiology Imaging Associates and such assistants as may be selected.

I understand that during the course of the procedure, unforeseen conditions may be revealed that necessitate an extension of the original procedure, or different procedures, than those set forth above. I therefore authorize the above named physician and his/her assistants to perform such diagnostic and therapeutic procedures as are deemed necessary in the exercise of professional judgment. I acknowledge that no warranty or guarantee has been made to me as to the results of the procedure(s).

The nature of the procedure(s) listed above, the risks involved, and the alternative procedures available, if any, have been explained to me. I have been given the opportunity to ask any questions that I have regarding the procedure(s), and my questions have been answered satisfactorily.

______________________________________________  ________________________________________
Signature of Patient           Witness

______________________________________________  ________________________________________
Signature of Relative or Guardian                  Relationship

Technologist:

- Is the patient using Glucophage/Glucovance (Metformin)?  Yes  /  No (circle one)
- If yes, was the patient informed of need to discontinue Glucophage/Glucovance (Metformin) for at least 24 hours after the exam, and to contact their physician to ensure normal renal function prior to restarting Glucophage/Glucovance? Yes / No (circle one)

Patient Signature: ______________________________    Date: ____________________________________
Technologist: _________________________________    Radiologist: _______________________________
Patient Name: ___________________________ Age/Sex: _____________
Patient #: _______________________________ Date: _______________
Ref. Dr.: ________________________________ Phone: _____________________
Ref. Dx. per Rx.: ____________________________________________________________________________

Patient Hx: ________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
Other related exams: __________________________________________________________________________

Allergies (incl. insects):

- Diabetic: No_____ Yes______
- Glucophage: No_____ Yes______
- Renal Disease: No_____ Yes______
- Mult. Myeloma: No_____ Yes______
- Asthma: No_____ Yes______
- Hypertension: No_____ Yes______
- Hay fever: No_____ Yes______
- Sickle Cell Anemia: No_____ Yes______
- Pheochromocytoma: No_____ Yes______
- Heart Condition: No_____ Yes______
- Any chance of pregnancy: No_____ Yes______
- Currently Breastfeeding: No_____ Yes______

*BUN / Creatinine levels if indicated: BUN____________________ / Creatinine: _____________________

Previous Contrast Injection: No_____ Yes______ Ionic or Non-Ionic? (circle one)

Adverse Reaction: No_____ Yes______ Notes: _____________________________________________________________________________________

Previous surgeries: __________________________________________________________________________

History of Cancer: __________________________________________________________________________

Radiation Therapy (Duration): ________________________ Date of last Rx: _____________________________

Chemotherapy: ________________________________ Date of last Rx: ______________________________

Contrast: ____________________________________________________________________________________

Amount: ___________________________ cc

● Contraindication for use of ionic contrast? Yes / No
● Patient pretreated with steroids? Yes / No

Criteria for use of Non-ionic: __________________________________________________________________

Injection Site: Right / Left: Antecubital, Forearm, Hand, Wrist, Other: ________________________________

Method: Power Injector, Butterfly, Angiocath, Other: ______________________________________________


Notes: _____________________________________________________________________________________

___________________________________________________________________________________________