Patient Name: ___________________________ Date: ______________________

Patient #: ______________________________ Time: __________________ am / pm

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/ACTOplus (Metformin)?  Yes / No (circle one)
- If yes, was the patient informed of need to discontinue Glucophage/Glucovance/ACTOplus (Metformin) for at least 48 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: ___________________________
Radiology Imaging Associates
IV Contrast Questionnaire

Patient Name: _____________________________________________ Age/Sex: _____________

Patient #: _________________________________________________ Date: ________________

Ref. Dr.: ____________________________________________ Phone: _____________________

Ref. Dx. per Rx.: __________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Patient Hx: _________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Other related exams: ___________________________________________________________________________

Allergies (incl. insects):

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucophage</td>
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<td></td>
</tr>
<tr>
<td>Renal Disease</td>
<td></td>
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<tr>
<td>Mult. Myeloma</td>
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</tr>
<tr>
<td>Asthma</td>
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<td></td>
</tr>
<tr>
<td>Heart Condition</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hypertension: No____ Yes____
Hay fever: No____ Yes____
Sickle Cell Anemia: No____ Yes____
Pheochromocytoma: 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: ___________________________________________________________________________