



RADIOLOGY CONSENT FOR USE OF CONTRAST

Your Physician has recommended that you undergo a procedure, commonly known as a CAT scan. This procedure may require the injection of contrast material or x-ray dye. The dye is used for many different exams every day, and there are many different brands of dye, but they all have essentially the same effect and purpose. They are used to make certain organs visible during the x-ray study that you are about to have.

Approximately 50% of patients experience a sensation of warmth throughout the body and a metallic taste in the mouth from the contrast. Other mild reactions that occur in less than 10% of patients and usually require no treatment include: nausea, vomiting, dizziness, coughing, itching and hives. Other reactions may be more severe and require treatment. They are relatively rare and occur in less than 1% of patients. They include difficulty breathing, spasms or fluid in the airways and lungs, kidney failure, cardiac failure, seizures, paralysis, quadriplegia, paraplegia, brain damage and coma. Death from the injection is rare.

A mechanical injector will be used to inject the contrast. With this type of injection, there is the possibility that some of the contrast may infiltrate (leak outside the vein). When there is a significant amount, surgery may be required in order to help minimize any potential problems. Please notify the technologist immediately if you notice a burning sensation or swelling in your arm at the injection site.

Before injection of this contrast material, it is important for the physician and the technologist to know if you have any of the following:

	YES	NO
Do you have diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, are you taking Glucophage, Glucovance, Metformin, Avandament, Riomet, Fortamet, or Metaglip?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a reaction to x-ray dye?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what happened? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have thyroid diseases?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have sickle cell anemia?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have kidney disease?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have multiple myeloma (a type of cancer)?	<input type="checkbox"/>	<input type="checkbox"/>
What medicines or foods are you allergic to? _____		
Females: Is there any chance you could be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
Date of last menstrual period, if of child bearing age? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever been diagnosed with cancer?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what type and what treatment have you had? _____	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had a CAT scan of this area before?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, when and where was it performed? _____		
Have you had previous surgery in the area being examined?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what type of surgery? _____	<input type="checkbox"/>	<input type="checkbox"/>

I have read the above information and give my consent to have this x-ray examination. I state that I was given the opportunity to ask questions about the procedure and all questions were answered in a satisfactory manner.

Signed: _____ Witnessed: _____

Relationship, If Not Patient: _____ Date: _____ Time: _____