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 and 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 to help minimize any potential problems. Please notify the technologist immediately if you notice a burning sensation or swelling in your arm at 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:

Height ____________ Weight ____________	YES	NO
Have you ever had x-ray dye (Iodinated C) or Betadine? ____________	☐	☐
Have you ever had a reaction to x-ray dye (Iodinated C} or Betadine? ____________	☐	☐
If yes, what happened? ____________		
Do you have kidney disease? ____________	☐	☐
Do you have diabetes? ____________	☐	☐
Do you have thyroid diseases? ____________	☐	☐
Do you have sickle cell anemia? ____________	☐	☐
Do you have myasthenia gravis? ____________	☐	☐
Do you have multiple myeloma (a type of cancer)? ____________	☐	☐
What medicines or foods are you allergic to? ____________		
Have you ever been diagnosed with cancer? ____________	☐	☐
If so, what type and what treatment have you had? ____________		
Have you ever had a CAT scan of this area before? ____________	☐	☐
If yes, when and where was it performed? ____________		
Have you had previous surgery in the area being examined? ____________	☐	☐
If yes, what type of surgery? ____________		
Females: Is there any chance you could be pregnant? ____________	☐	☐
Date of last menstrual period, if of childbearing age ____________		

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: ____________________