

CONSENT FOR CONTRAST INJECTION

Your doctor has scheduled you for a radiological examination that requires an injection of contrast media into your bloodstream to help the Radiologist interpret your exam. The contrast media is injected through a small catheter placed into a vein in your arm or hand. Contrast media is considered quite safe; however, any injection carries a slight risk such as infection or injury to the nerve, artery, or vein. The most common side effect is a warm or flushed sensation, although patients may have a mild reaction to the contrast media and develop sneezing or hives. Our physicians and staff are trained to treat these reactions. In addition, we use non-ionic contrast to further reduce the risk of adverse effects.

Please answer the following questions:

1. Have you ever had a CT before? YES _____ NO _____
If yes, where? _____
2. Have you ever had any surgery? YES _____ NO _____
If yes, please list _____
3. Do you have any allergies? YES _____ NO _____
If yes, please list _____

Do you have reactions of the skin that causes hives or rashes? YES _____ NO _____
If yes, please list _____
4. Are you allergic to Iodine or X-Ray dye? YES _____ NO _____
5. Do you eat shellfish (i.e. shrimp)? YES _____ NO _____
If no, why? _____
6. List all medications you are currently taking: _____

ARE YOU CURRENTLY TAKING ANY METFORMIN (DIABETIC) PRODUCT YES _____ NO _____

7. Date of last menstrual period _____
Are you pregnant or breast-feeding? YES _____ NO _____
8. Do you have personal history of:

	YES	NO		YES	NO
Suspected Heart Attack	_____	_____	Severe Arrhythmia	_____	_____
Recent Heart Attack	_____	_____	Multiple Myeloma	_____	_____
Prior Reactions to Iodine	_____	_____	Kidney Disease	_____	_____
Unstable Angina	_____	_____	Heart Disease	_____	_____
Congestive Heart Failure	_____	_____	Hypertension	_____	_____
Elevated Creatinine	_____	_____	Hay Fever	_____	_____
Blood Disorder (i.e. Sickle Cell)	_____	_____	Diabetes	_____	_____
Kidney Transplant	_____	_____	Asthma	_____	_____
9. Do you have personal history of Cancer? YES _____ NO _____
If yes, what type? _____
Have you ever had Chemotherapy or Radiation? YES _____ NO _____

If yes, date of last chemo or radiation treatment: _____

10. Please describe the symptoms you are having now---Why are you here today? _____

11. Have you recently had blood work? If so, where? _____
12. Do you have a power port? YES _____ NO _____

I have read the above information and have had my questions answered. I give my consent to have this injection.

Print Name _____ Date _____
Signature _____ Witness (Technologist) _____