Consent for Contrast Injection
Computed Tomography (CT)
and
Medical History Form

Date of Issue: 06/2009
Revised Date: 08/19/2013
08/13/2014
12/02/2014

Your doctor has scheduled you for a radiological examination that may require 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 or if appropriate through your Power Port or PICC Line. Contrast media is considered quite safe; however, any injection carries a slight risk such as infection or injury to the nerve, artery, or vein. It is possible to have bruising or swelling at the IV site after this test. Rare, but possible is for the IV contrast to either leak or be injected into the tissue when the vein fails. This is called extravasation. If the extravasation is large enough, the radiologist may request that you go to an Emergency Department for evaluation and treatment of the swelling and circulation of the extremity. 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___

4. Are you allergic to iodine or X-Ray dye?  
   Yes___No___

5. Your current weight  
   ________________

6. List all medications you are currently taking ____________________________________________________________
   _________________________________________________________________________________________________

7. Date of your last menstrual period  
   ________________

8. Are you pregnant or breast feeding?  
   Yes___ No___

9. Do you have a personal history of:

   Suspected Heart Disease  Yes___No___
   Recent Heart Attack     Yes___No___
   Prior Reactions to Iodine Yes___No___
   Unstable Angina         Yes___No___
   Congestive Heart Failure Yes___No___
   Elevated Creatinine     Yes___No___
   Blood Disorder (i.e. Sickle Cell) Yes___No___
   Kidney Transplant       Yes___No___
   Severe Arrhythmia       Yes___No___
   Multiple Myeloma        Yes___No___
   Kidney Disease          Yes___No___
   Heart Disease           Yes___No___
   Hypertension            Yes___No___
   Hay Fever               Yes___No___
   Diabetes                Yes___No___
   Asthma                  Yes___No___
10. If you answered yes to Diabetes, please circle below the medications you are taking for the treatment of your Diabetes:

<table>
<thead>
<tr>
<th>Fortamet</th>
<th>Glucophage</th>
<th>Glucovance</th>
<th>Glumetza</th>
<th>Actoplus Met</th>
<th>Metaglip</th>
<th>Metformin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avandamet</td>
<td>Insulin</td>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The risks and complications of taking Metformin or Metformin containing products (Glucophage, Glucovance, Avandamet, or Metaglip), after an iodinated contrast injection, have been explained to me. I hereby state that I will not take this medication: Metformin, Glucophage, Glucovance, Avandamet, or Metaglip for another 48 hours following intravenous injection of iodinated contrast necessary for my diagnostic radiological examination. I will contact my doctor, Dr.________________________at________________________to arrange repeat bloodwork (BUN and Creatinine). I understand that I may contact my doctor before this study if I have any questions, or am uncertain whether I am on this medication.

| Is your Diabetes diet controlled? | Yes | No

11. Regarding the area we are imaging today, have you had ...

When and describe

| Injury to area | Yes | No
| Surgery to area | Yes | No
| Cancer | Yes | No
| Radiation/Chemotherapy | Yes | No

12. In the past, have you had ...

When and describe

| MRI/CT | Yes | No
| Ultrasound | Yes | No
| PET scan | Yes | No
| Nuclear Scan | Yes | No
| X-Ray | Yes | No
| Mammography | Yes | No

13. Do you have a personal history of Cancer? Yes | No

If yes, what type? ______________________________________________________________________

Have you ever had Chemotherapy or Radiation? Yes | No

If yes, date of last Chemotherapy and/or Radiation treatment ___________

14. Please describe the symptoms you are having now and why are you here today? __________________________________________________________

_____________________________________________________________________________________________

15. Have you recently had blood work? If so, where? ______________________________________________________________________

16. Do you have a Power Port? Yes | No

If yes, is it operational/functional and if so, do you want us to access for your contrast administration today? Yes | No

I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT FORM. I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT. I CONSENT TO HAVE THIS INJECTION AS DESCRIBED ABOVE.

Print Name________________________________________________________________________Date________________________

Signature ______________________________

Witness ______________________________(RT or RN)