MEDARVA IMAGING

CT IV Contrast Informed Consent

Patient Name: ______________________________ Date of Exam: ____________________

Contrast Information

As requested by your physician, CT contrast may be necessary to aid the radiologist in evaluating your scan. The use of this solution helps to visualize certain organs inside the body that are not normally seen well and provides the radiologist with information that is necessary in evaluating your exam.

The contrast agent is given through a small needle placed into a vein, usually on the inside of your elbow or on the back of your hand. The Food and Drug Administration has approved this agent and it is considered quite safe; however any injection carries a risk of harm including injury to a nerve, artery or vein, extravasation of the contrast under the skin, infection, potential or renal injury; or reaction to the contrast itself.

A small percentage of patients receiving CT contrast may develop a mild allergic reaction, the most common being hives. Same patients develop sneezing or itchy, watery eyes. Mild allergic reactions such as these are typically treated with antihistamine. Uncommonly, more serious reactions have been known to occur, including life-threatening reactions. These serious reactions are rare.

Screening Questions

Answer the following questions so we may evaluate if you are at high risk for an adverse contract reaction.

- ☐ Yes ☐ No *Female Only:* Any chance you are pregnant? Are you breastfeeding? ☐ Yes ☐ No
- ☐ Yes ☐ No Have you ever had a reaction to x-ray contrast? Type of reaction? ____________________
- ☐ Yes ☐ No Do you have allergies? If yes, to what? ______________________________
- ☐ Yes ☐ No Do you have asthma?
- ☐ Yes ☐ No Have you ever had kidney disease?
- ☐ Yes ☐ No Have you ever had kidney/renal surgery?
- ☐ Yes ☐ No Have you ever had a kidney injury?
- ☐ Yes ☐ No Do you have history of myeloma?
- ☐ Yes ☐ No Do you have history of collagen vascular disease?
- ☐ Yes ☐ No Do you have history of sickle cell anemia?
- ☐ Yes ☐ No Do you have Congestive Heart Failure or Heart Disease?
- ☐ Yes ☐ No Do you have a history of diabetes? If yes, insulin dependent? ☐ Yes ☐ No
- ☐ Yes ☐ No Do you take any of the following medications? Circle any metformin medications that apply. Metformin: Glucophage, Glucovance, Fortamet, Glumetza, Riomet, Metaglip, Avandamet, Acto Plus Met, Other Metformin-containing drug: ______________________________
- ☐ Yes ☐ No Long term use of non-steriodal anti-inflammatory drugs
- ☐ Yes ☐ No Regular use of nephrotoxic antibiotics, such as aminoglycosides
- ☐ Yes ☐ No Medication for hypertension (high blood pressure) If yes, what? ____________________

Patient Attestation

If you have questions regarding your exam, please talk with the Technologist prior to your scan.

Your signature on this form indicates you: (1) Have read and understood the information provided on this form; (2) Have been informed about this procedure; and (3) Had a chance to ask questions.

☐ I CONSENT to have CT contrast as needed. (Check box if you agree to contrast)

☐ I DECLINE having a CT contrast injection at this time. (Check box if you disagree to contrast)

Patient Signature: ______________________________ Date: ______________

If a patient is a minor or has a legal guardian, the parent or guardian must sign for consent.

Parent/Guardian Signature: ______________________________ Date: ______________

Technologist Signature: ______________________________ Date: ______________