



PATIENT NAME _____ PROCEDURE _____

I, the undersigned, authorize the attending Radiologist and whomever he may designate as his assistant to perform the above listed x-ray procedure requiring the administration of a contrast media (listed below). The contrast media is a liquid substance consisting of an iodine bound compound. It is injected into the body to produce visualization of the body or organs being x-rayed.

I also consent to the administration of such medications as may be considered necessary and advisable by the radiologist responsible for this exam. The medication is of a counter-reactionary type to be administered in the event of a reaction to the contrast media because of medication allergies which I may encounter after receiving the contrast media.

In studies requiring the intravascular injection of the contrast agent, you may experience a mild hot flash that will last several minutes. You may also develop a transient bitter taste or a warm feeling in the throat or mouth. Approximately 10% of all people experience mild nausea and vomiting or may develop hives. Serious or life threatening reactions occur approximately one in every 15,000 to 30,000 cases.

If you have a known allergy to iodine, please inform us. People with a strong allergic history, asthma and previous contrast reactions have a higher risk for complication.

PATIENT OR PATIENT REPRESENTATIVE'S ACKNOWLEDGMENT

I acknowledge that I have read and fully understand the above consent; that I had the opportunity to ask the radiologist any questions and received answers to those questions; and that all blanks or statements requiring insertion or completion were filled in before I affixed my signature.

- a. I have no known allergies _____ (patient initials)
- b. I am allergic to the following _____
- c. Do you have asthma? Yes No
- d. Have you ever had contrast media, iodine or x-ray dye? Yes No
- e. If yes, did you have a reaction to it? Yes No
- f. Do you have history of heart disease Yes No Heart Surgery? Yes No
- g. Are you taking any blood thinners (anticoagulants)? Yes No
- h. Do you have diabetes? Yes No
- i. If yes, do you take Glucophage or Metformin? Yes No
- j. Weight _____

SIGNATURE OF PATIENT OR REPRESENTATIVE _____

RELATIONSHIP TO PATIENT (IF REPRESENTATIVE) _____

DATE _____

<p>TECHNOLOGIST USE ONLY</p> <p>Tech initials _____</p> <p>IV CONTRAST _____ ML</p> <p>ORAL CONTRAST YES NO _____ CC</p> <p>LAB VALUES: DATE OF TEST _____ BUN _____ CREATININE _____ GFR _____</p>	<p>HISTORY:</p>
--	------------------------