ALTUS™ HOSPITAL

Patient Label

CONTRAST CONSENT FORM

Have you had radiographic contract material injected into your veins? Yes No
If YES, Did you experience any problems with the injection? Yes No

If YES, Please list:_____

Are you allergic to any medication/foods: Yes No

If YES, Please list: _____

Do you have a history of Asthma? Yes No
Diabetes? Yes No
Which mediation are you currently taking? _____

All medical procedures and exams involve an element of risk. It is our intention to inform you of the risks involved with your procedure today. Minor allergic reactions suck as hives, slight wheezing, and/or watery eyes can occur when receiving imaging contrast. More severe reaction such as difficulty breathing, cardiac arrest, sudden drop in bl ood pressure, and loss of consciousness c an occur on rare occasions (approximately 4 out of 10,0000 cases). Your risk for reaction is increased if you have asthma or multiple allergies. You have been screened prior to this exam to insure your risks are minimized. Die to the nature of the examination, the technologist will use a mechanical injector to administer the contrast via IV. There is no way for us to determine if a vein can withstand the injection. Occasionally, contrast can leak from the vein or cause it to rupture. The least irritat ion and damaging contrast is used here at our facility. However, any leaked contrast could be irritating and damaging to your skin. If this happens, you will be treated immediately by the technologist and a nurse will be called. Follow up care can be ar ranged with your referring physician if needed.
Your doctor has considered these risks before recommending this examination. He/she believes that the diagnostic benefits outweigh the risks involved. The nature and risk of the radiographic examination per formed today was explained to you by a licensed radiologic technologist.
If patient is over 60 years old: GFR level _____
I consent to use of contrast for my exam today as ordered by my physician. Yes No
I understand all the information provided Yes No
I have question about exam Yes No

_____ _____

Signature of Patient/Guardian Date Signature of Technologist Date

IV Size: _____Location:_____ Inserted by: _____

IV Size 2nd attempt _____ Location: _____ Inserted by: _____

Contrast Amount: _____ Type of Contrast: _____

Notes: _____