CONSENT FOR INJECTION OF INTRAVENOUS CONTRAST MATERIAL

Technologist Only: (If Over 70 years old) BUN: _____ CREATININE: _____

Your Doctor has requested an examination which requires the injection of contrast material (DYE) into you. The contrast goes through your body and is eliminated by your kidneys. Complications resulting from these examinations are infrequent and include but are not limited to: Nausea, Hives, vomiting, rash and rarely kidney failure or death. Patients often report only a warmth or blushing feeling after the contrast agent is injected.

Patient History:

1. Do you have any known medical allergies? (Allergic to medications) ___ Yes ___ No
   List: _____
2. Are you allergic to **IODINATED CONTRAST?** ___ Yes ___ No
   What kind of reaction did you have?
   Hives-**Need to be Pre-Medicated**
   Difficulty Breathing-**No Contrast**
3. Are you allergic to seafood? ___ Yes ___ No
   Hives-**Need to be Pre-Medicate**
   Difficulty Breathing-**No Contrast**
4. Do you have Asthma? ___ Yes ___ No
5. Are you on Dialysis? ___ Yes ___ No
6. Do you have Sickle Cell Anemia or Sickle Cell Trait? ___ Yes ___ No
   If yes, please describe what medications you are on.
   _____
7. Could you be **Pregnant/Breastfeeding?** ___ Yes ___ No
8. Are you a Diabetic? ___ Yes ___ No
   If yes, how do you control you diabetes.
   Diet_____/Medication_____
   If patient is on medication such as Glucophage, (Metformin), Avandamet or Glucovance, the patient must **Stay Off** these medications for 48 hrs after the test. The patient **CAN TAKE THEM** the morning of the test.
9. Do you have any of the following: (Please circle all that apply)
   Hyperthyroidism Heart Failure Chronic Lung Disease High Blood Pressure Heart Disease Multiple Myeloma Known Renal (kidney) Disease any Cancer History
10. Symptoms related to todays exam: _____
11. Any past surgical history in the area to be scanned: (please describe)
    _____
    _____

I have read this form and answered the questions to the best of my knowledge. I understand that there is some risk to these procedures with no guaranteed benefits. I hereby request and authorize performance of the above examinations.

Patient signature: _____ Date: _____

Technologist signature: _____