



Radiology Imaging Associates

IV Contrast Consent Form

Patient Name: _____ Date: _____

Patient #: _____ Time: _____ am / pm

Dear Patient:

Your doctor has requested an examination that requires the injection of contrast media in a vein in your arm. This will enable us to image specific internal structures of the body. The contrast may cause you to feel sensations such as a “metallic” taste in the mouth, coolness in arm, a general warmth, or nausea. These sensations are normal and will pass within a couple of minutes, or you may not feel them at all. A few patients experience allergic type reactions to the contrast, usually in the form of hives or itching. In rare cases, death has resulted. Since fatal reactions are so rare, it is difficult to quote accurate numbers, but it has been estimated to occur in less than 1 in 100,000 examinations. Your doctor is professionally knowledgeable of the procedure and the risks, and is recommending that you have the examination. Serious reactions to the contrast media are not common. Our doctors will be willing to answer any questions concerning the procedure.

Consent:

I, _____, hereby consent to the following procedure(s), _____, to be performed by Radiology Imaging Associates and such assistants as may be selected.

I understand that during the course of the procedure, unforeseen conditions may be revealed that necessitate an extension of the original procedure, or different procedures, than those set forth above. I therefore authorize the above named physician and his/her assistants to perform such diagnostic and therapeutic procedures as are deemed necessary in the exercise of professional judgment. I acknowledge that no warranty or guarantee has been made to me as to the results of the procedure(s).

The nature of the procedure(s) listed above, the risks involved, and the alternative procedures available, if any, have been explained to me. I have been given the opportunity to ask any questions that I have regarding the procedure(s), and my questions have been answered satisfactorily.

Signature of Patient

Witness

Signature of Relative or Guardian

Relationship

Technologist:

- Is the patient using Glucophage/Glucoavance (Metformin)? **Yes / No** (circle one)
- If yes, was the patient informed of need to discontinue Glucophage/Glucoavance (Metformin) for at least 24 hours after the exam, and to contact their physician to ensure normal renal function prior to restarting Glucophage/Glucoavance? **Yes / No** (circle one)

Patient Signature: _____ Date: _____

Technologist: _____ Radiologist: _____



Radiology Imaging Associates
IV Contrast Questionnaire

Patient Name: _____ Age/Sex: _____

Patient #: _____ Date: _____

Ref. Dr.: _____ Phone: _____

Ref. Dx. per Rx.: _____

Patient Hx: _____

Other related exams: _____

Allergies (incl. insects): _____

- Diabetic: No Yes Hay fever: No Yes
Glucophage: No Yes Sickle Cell Anemia: No Yes
Renal Disease: No Yes Pheochromocytoma: No Yes
Mult. Myeloma: No Yes Heart Condition: No Yes
Asthma: No Yes Any chance of pregnancy No Yes
Hypertension: No Yes Currently Breastfeeding No Yes

*BUN / Creatinine levels if indicated: BUN _____ / Creatinine: _____

Previous Contrast Injection: No Yes Ionic or Non-Ionic? (circle one)

Adverse Reaction: No Yes Notes: _____

Previous surgeries: _____

History of Cancer: _____

Radiation Therapy (Duration): _____ Date of last Rx: _____

Chemotherapy: _____ Date of last Rx: _____

Contrast: _____ Amount: _____ cc

- Contraindication for use of ionic contrast? Yes / No Patient pretreated with steroids? Yes / No

Criteria for use of Non-ionic: _____

Injection Site: Right / Left: Antecubital, Forearm, Hand, Wrist, Other: _____

Method: Power Injector, Butterfly, Angiocath, Other: _____

Sharps: 18G, 19G, 20G, 21G, 22G, 23G, Other: _____

Notes: _____