INFORMED CONSENT FOR INJECTION OF CONTRAST MEDIA

DOCTOR: ___________________________ HAS REFERRED YOU FOR A ___________________________
TO OBTAIN DIAGNOSTIC INFORMATION THIS EXAMINATION MAY REQUIRE AN INJECTION OF IODINATED
CONTRAST MEDIA (ALSO KNOWN AS XRAY DYE), WHICH ENHANCES BODY ORGANS AND BLOOD VESSELS.

MOST PATIENTS EXPERIENCE A WARM SENSATION DURING THE INJECTION. AN ALLERGIC TYPE REACTION TO
THE INJECTION IS ALSO POSSIBLE. THE MOST COMMON REACTIONS INCLUDE NAUSEA, VOMITING, FLUSHING
AND SNEEZING. OTHER REACTIONS MAY INCLUDE HIVES, CHILLS, SWELLING OF THE EYES AND LIPS,
SWEATING, DIFFICULTY BREATHING, CARDIAC ARRHYTHMIAS AND RENAL FAILURE. RARE INSTANCES OF
PROGRESSION TO DEATH DUE TO COMPLICATIONS HAVE BEEN REPORTED. HOWEVER, MEDICATIONS AND
TRAINED PERSONNEL ARE ON HAND TO TREAT THESE CONDITIONS SHOULD ANY OCCUR. YOUR PHYSICIAN IS
AWARE OF THESE POSSIBLE COMPLICATIONS BUT HAS DETERMINED THAT THE DIAGNOSTIC INFORMATION
THAT THE EXAM PROVIDES FAR OUTWEIGHS THE MINIMAL RISK OF THE PROCEDURE.

1. HAVE YOU EVER HAD A REACTION TO THE INJECTION OF CONTRAST MEDIA THAT REQUIRED
   MEDICAL TREATMENT? YES ______ NO ______
2. DO YOU HAVE ALLERGIES TO ANY TYPE OF FOOD OR MEDICATIONS? YES ______ NO ______
3. DO YOU HAVE HAYFEVER OR ASTHMA? YES ______ NO ______
4. DO YOU HAVE ANY HEART DISEASES, ARRHYTHMIAS, CONGESTIVE HEART FAILURE OR SUFFERED A
   RECENT HEART ATTACK? YES ______ NO ______
5. IS THERE A CHANCE YOU COULD BE PREGNANT? YES ______ NO ______
6. ARE YOU CURRENTLY BREAST FEEDING? YES ______ NO ______
7. ARE YOU DIABETIC? ON METFORMIN OR GLUCOPHAGE? YES ______ NO ______

I ___________________________ CERTIFY THAT I HAVE READ AND UNDERSTOOD THE ABOVE PRESENTED
INFORMATION AND THAT ALL MY QUESTIONS REGARDING THIS EXAMINATION HAVE BEEN ANSWERED TO MY
SATISFACTION. I HEREBY AUTHORIZE DR. AJAY GOYAL OR A QUALIFIED PHYSICIAN OR TECHNOLOGIST TO
PERFORM THE EXAMINATION AND ADMINISTER AN INJECTION OF CONTRAST MEDIA. IF ANY COMPLICATIONS
SHOULD OCCUR I HEREBY CONSENT TO ANY ADDITIONAL TREATMENT NECESSARY.

PATIENTS SIGNATURE: __________________________________________ DATE: ___________
WITNESS SIGNATURE: __________________________________________ DATE: ___________

CONTRAST TYPE: ___________________________ AMOUNT: ____________ CC’S
IV SITE: ___________________________ NEEDLE GAUGE USED ________