DIAGNOSTIC RADIOLOGY CENTER OF THE TREASURE COAST, INC.

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BOARD CERTIFIED RADIOLOGIST

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 INLCUDE 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 POSSIBILE 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 _____