PROGRESSIVE RADIOLOGY

CT WITH OR WITHOUT CONTRAST AND/OR IVP CONSENT FORM

Patient Name: _____

You have the right to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you. It is so that you may choose to give or withhold consent for this procedure.

Your physician has requested that we perform a computerized tomography scan (CT) or Intravenous Pyelogram (IVP) to obtain additional information. This is a diagnostic test that uses x-rays to produce images of internal body parts. As part of your exam, a contrast agent may be injected into your vein in order to produce better images of the part of the body being examined.

Potential Risks— The following complications are possible whenever an injection is given. There is a potential for pain, bleeding, bruising or swelling at the injection site. Allergic reactions in response to the contrast agent may include hives, shortness of breath or difficulty swallowing. There have been rare instances of death after the administration of a contrast agent.

If you are pregnant or think that you may be pregnant, please inform our staff immediately.

If you are breast-feeding, you should pump and discard your breast milk two times over a 24 hour period following this test. It is safe to resume breast-feeding 24 hours after this test.

If you have had a previous reaction to a contrast injection such as hives, severe itching, shortness of breath and/or any other significant reaction requiring hospitalization, a history of asthma or allergic conditions, any history of anemia, sickle cell anemia or kidney disorders, or are breast feeding, please inform the technologist. **In addition, if you are taking any of the following drugs, you *must* inform the technologist: Glucophage, Glucovance, Glumetza, ActopPlus Met, Avandemet, Fortamet, Metaglip, or Riomet.**

An alternative to this procedure may be an ultrasound, x-ray, MRI or no treatment. However, your physician believes this test to be the best diagnostic test for you. The benefit of the exam is to assist your physician with a diagnosis.

I (we) certify this form has been fully explained to me, that I (we) have read it or have had it read to me, and that we understand its contents. I (we) have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used and the risks and hazards involved. I (we) believe that I (we) have sufficient information to give this informed consent.

_____ _____

Signature of Patient or Authorized Representative Date

For Clinical Use Only – Contrast Administration

_____cc of _____ contrast injected at _____ AM/PM

Contrast Lot #_____

❑Contrast Reaction or Extravasation *(If yes, explain)*:_____

_____

_____ _____

Signature of Technologist *Date*