

INFORMED CONSENT FOR IODINE CONTRAST INJECTION

Patient Name: _____ VMR Account #: _____ DOB: _____

You have the right, as a patient, to be informed of the risks and hazards involved with the diagnostic procedures(s) to be performed so that you make the decision whether or not to undergo the procedure(s). This disclosure is not meant to frighten or alarm you. It is simply an effort to make you better informed so you may give or withhold your consent for the procedure.

Your doctor has requested a/an _____, which requires the administration of an iodine-containing compound. Please read the following discussion.

A small percentage of patients report symptoms such as a metallic taste or a warm sensation throughout the body. Nausea and/or vomiting is rarely associated with the contrast but these signs and symptoms are usually transient and generally do not require any treatment.

A small percentage of patients may develop a reaction to contrast injection. A “MINOR” reactions such as sneezing, red eyes, runny nose, and itching indicate a mild allergic reaction, and are generally not life threatening. Swollen tongue, difficulty in breathing, generalized urticaria, shock, etc., indicate “MAJOR” reactions, which are serious and may be life threatening and require emergency treatment. The risk of developing a “MAJOR” reaction is much less if you had no problems with contrast injections in the past. Inform the Radiologist of previous allergic reaction(s).

Have you ever had?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	A reaction to Iodine contrast	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sickle Cell
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Reaction to any contrast	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney/Urinary problems
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Allergies (food, medication)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Allergic/sensitivity to Iodine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Myeloma
<input type="checkbox"/> Yes	<input type="checkbox"/> No	A severe/mild allergic reaction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Diabetes
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Asthma/Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you currently taking medication that contain Metformin? (i.e. Metaclicp, Acandamet, Glucophage, Glucovance)
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Respiratory Inhalers			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	Are you 50 years of age or older?			

Women: Is there a possibility that you may be pregnant? Yes No

Have you had surgical sterilization? Yes No

Date of last menstrual cycle: _____

Are you currently breast-feeding? Yes No

I am aware of the possibilities and accept all responsibility for any such reaction(s) and consequences. I will not hold the facility, physicians, contractors, or personnel responsible for any such reaction(s).

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Laboratory results: _____ **BUN** _____ **Creatinine** _____ **Date of lab work:** _____

Date of follow up lab work (if applicable): _____

Contrast: _____ Qty Given: _____ # of Attempts: _____

Needle Size: _____ Injection Site: _____ Time: _____

Contrast Extravasation? _____ Contrast Reaction? _____

If Yes, Please explain: _____

Technologist Signature: _____