

Consent for Contrast Injection

Patient's Name _____ Age _____ Date _____

1. The procedure(s) necessary to treat my condition has/have been explained to me by a licensed medical professional and I understand the nature of the procedure to be: Insertion of a needle into the vein of the arm to inject non-ionic contrast (dye) which goes in the blood stream. X-rays are taken to determine if there are any problems in the areas being examined.
2. I have been made aware of certain risk(s) and consequences that are associated with the procedure described above. These are: Allergy to non-ionic contrast (dye); i.e. itching, hives, nausea and/or vomiting. Swelling and breathing problems can be fatal but are extremely rare.
3. I certify that I have read the above paragraphs and understand them. I authorize the procedure described above.
4. I, hereby, give consent for the injection of non-ionic contrast (dye) and fully understand the above.

SIGNATURE OF PATIENT: _____

SIGNATURE OF AUTHORIZED TO CONSENT FOR PATIENT: _____

RELATIONSHIP TO PATIENT: _____

WITNESS: _____

RADIOLOGIST: _____

PREGNANCY INFORMATION

If not applicable, please circle: (N/A)

Recognizing that there is a very small, but unknown risk to a developing fetus exposed to diagnostic levels of radiation, it is imperative that every effort is made to avoid unnecessary exposure to the fetus. For this reason, we require all females ages 12 to 55 to answer the following questions, before proceeding with your x-ray examination.

Patient's Name: _____

Females 12-55 years of age, please answer the following questions:

I understand that radiation can be harmful to the unborn child.

Date of last menstrual period: _____.

Please complete the following:

- I am pregnant.
- I may be pregnant.
- I am not pregnant.

Patient Signature

Date

Parent or Guardian, if under 18

Date