

Patient Name: _____

NAME & DESCRIPTION OF TEST: MRI Arthrogram with Contrast (Gadolinium)

TO UNDERSTAND THE MEDICAL CONDITION: _____

You are scheduled for an MRI imaging test by your doctor. This uses magnetic fields, radio waves and computers to look deeply inside your body. Your doctor believes this test will provide information, which should help us better understand, and treat you medical problem. As part of your test, you will be given some contrast media containing gadolinium. This is injected in a vein before or while pictures are being made. Gadolinium is a safe drug, but there are some occasional side effects. The doctors, nurses, and technologists of the Imaging Center are trained to treat these reactions if they occur.

POTENTIAL BENEFITES/ POSSIBILITY OF SUCCESS: See description above.

OTHER POSSIBLE WAYS TO UNDERSTAND YOUR MEDICAL CONDITION:

While we could perform your test without contrast media, the test could be of little use and may not help to give a completely accurate diagnosis of your illness.

In your case, other possible imaging and/ or types of tests include:

MR without contrast	CT with Contrast	Nuclear Medicine
Ultrasound	CT without Contrast	Plain film X-Ray
MR Arthrogram: _____	Right: _____	Left: _____

WHAT WILL HAPPEN IF THE TEST IS NOT DONE: Unknown

RISKS OF THIS TEST:

The types of reactions you might have are:

1. Minor Reactions: Headache or an upset stomach, which require no treatment. Itching or rash may require minor treatment. Leakage, bruising, or infection might occur at the injection site. The chance of a minor reaction is less than 1 in 100 or 1 percent.
2. Serious Reactions: These side effects cause harm and may be life-threatening usually requiring medical treatment. They include breathing problems, losing consciousness, or heart beat irregularly. The change of a serious reaction is about 1 in 25,000 or 0.004 percent.
3. Death: Like many drugs, it is possible that contrast media can cause death. Only one death from gadolinium had been reported.

Nephrogenic Systemic Fibrosis (NSF) or Nephrogenic Fibrosing Dermopathy (NFD) is a disease in people with kidney disease or kidney failure that is usually very rare. It may occur more often in people with kidney disease or failure who have had injections of gadolinium containing contrast media in their veins. Patients with NSF/NFD have tight and stiff skin making it difficult to bend joints. It may also result in fibrosis or scarring of body organs so that the body organs are not able to work properly. This can lead to death. At this time, we cannot estimate the chance for this reaction.

If you have any questions, please ask the technologist, nurse, or physician.

CONSENT TO TREAT:

I understand that medicine is not exact. I accept that I have not received any guarantees or promises about the results of this test. I understand the risks of this test. All medical procedures have some risk. I understand the risks of any medical procedure may include infection, allergic reaction, severe loss of blood, loss of function of any limb or organ, paralysis or partial paralysis, paraplegia, quadriplegia, disfiguring scar, brain damage, cardiac arrest, or death.

I accept and understand that this consent can be used for the responsible physician. It can also be used for all medical staff under the direct supervision and control of the responsible physician and all other medical staff involved in this test.

By signing below, I stat that I have read this form or had this form read and/or explained to me. I agree that I have been given the chance to ask questions. I agree that my questions have been answered to my satisfaction. I understand this form. I voluntarily agree to allow the test described above to be performed. I allow the test to be performed by a radiologist or any physician working with him or her, all medical staff under the direct supervision and control of such physician, and all other staff who may involved in doing said test.

Name of Patient

Date

Signature of Patient or Authorized Guardian

Signature of Witness

Signature of Radiologist

Date

OR

IF PATIENT **DOES NOT WANT TO KNOW** ABOUT RISKS, BENEFITS, OTHER POSSIBLE WAYS TO UNDERSTAND HIS OR HER MEDICAL CONDITION OR WHAT WILL HAPPEN IF THE TEST IS NOT DONE, PATIENT MUST SIGN WAIVER BELOW.

PATIENT WAIVER OF CONSENT

I do not wish to be told of the risks, other possible ways to understand my medical condition, or what will happen if the test is not done, but I do wish to have the test named above performed. I understand that I am agreeing to the test without knowing the information described in this form.

Name of Patient

Date

Signature of Patient or Authorized Guardian

Signature of Witness

Signature of Radiologist

Date