

**INFORMED CONSENT TO DIAGNOSTIC
PROCEDURE USING CONTRAST MEDIA**

NAME: _____ DOB: _____

PROCEDURE: _____ DATE: _____

The diagnosis or clinical history requiring this procedure is:

The purpose of this procedure is: To obtain images with greater diagnostic information

I acknowledge and understand that the injection of a CONTRAST MEDIA is required to complete this procedure. I understand that the contrast will be injected into my body for the purpose of providing a density difference in the tissues, organs or vessels to be studied. I understand that my body may react to the contrast media in fashions including, but not limited to the following:

- A. NONE Many patients experience no reaction to the contrast media.
- B. MILD Some patients experience a general “warm” feeling similar to suddenly walking into a very warm room. This condition usually subsides very quickly. Some patients may experience hives, itching, or nausea, which can be treated if the condition does not pass relatively quickly.
- C. SEVERE In rare instances, some patients may experience a severe allergic reaction to the contrast media. In these instances, patients may experience respiratory and/or cardiac arrest, renal failure, brain damage, death, severe loss of blood, loss of function of a limb or an organ, paralysis or partial paralysis, paraplegia, or quadriplegia, or disfiguring scar. Some of the risks listed above may not be the direct result of the contrast media, but may be the result of the emergency care required to treat the allergic reaction to the contrast media.

I acknowledge and understand that during the course of the procedure specified above, conditions may develop which may reasonably necessitate an extension of the original procedure(s) or the performance of the procedure(s) which is unforeseen or not known to be needed at the time this consent is obtained. I therefore consent to and authorize the persons named in this consent to make decisions concerning the performance of and to perform such procedure(s) as they may deem reasonably necessary or desirable in the exercise of their professional judgment including those procedures that may be unforeseen or not known to be needed at the time this consent is obtained.

The likelihood of success of this CT procedure is Good Fair Poor

I acknowledge and understand that there are other procedures such as Nuclear Medicine scan, MRI, CT without contrast, Ultrasound, Arteriogram and other surgical procedures, which may yield diagnostic information pertaining to my condition, however, these procedures may not provide the same depth of information or may not have less associated risks.

I understand that the physician, medical personnel and other assistants will rely on statements about the patient, the patient’s medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient’s condition and in recommending the procedure which has been explained.

I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure.

I consent to the use of IV Contrast Material, and understand the risks are those associated with the procedure itself as listed above. The options have also been explained to me.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME IN GENERAL TERMS AND THAT I FULLY UNDERSTAND ITS CONTENTS, THAT I HAVE HAD AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ANY QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRIKEN BEFORE I SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION, INCLUDING, BUT NOT LIMITED TO THE MATERIAL BELOW, RELATED TO THE PROCEDURES DESCRIBED HEREIN.

Additional materials used, if any, during the informed consent process for this procedure include _____.

Patient Signature

Date

Relationship to Patient if not the patient: _____

Patient unable to sign because: _____

Sign here if Patient/Person giving consent has refused the procedure: _____

Witnessed By: _____

Technologist Signature: _____