

Name:

Date of Birth:

Referring Physician:

Servant Medical Imaging - CT Contrast Advisory and Consent

- Yes No Are you diabetic?
- Yes No Do you take glucophage/metformin/glucoavance?
- Yes No Are you pregnant or nursing?
- Yes No History of asthma?
- Yes No History of chronic renal disease, kidney failure or dialysis?
- Yes No History of liver disease?
- Yes No History of hypertension?
- Yes No Have you had chemotherapy?
- Yes No History of heart disease or angina?
- Yes No History of Pheochromocytoma? (adrenal gland tumor)
- Yes No History of Multiple Myeloma? (a bone marrow cancer)
- Yes No History of abnormal red blood cells?
- Yes No Do you have any food or drug allergies?
List: _____
- Yes No Any reaction to a previous contrast injection?
Explain: _____
- Yes No Have you had blood lab work in the past 30 days?
Where? _____
- Yes No Have you had any surgeries? Please list below:

As part of your examination, the radiologist may deem it advisable to give you an I.V. injection of a contrast agent. This injection may help the physician more accurately diagnose your condition. Although adverse reactions are very rare, please be advised that there may be leakage at the injection site, pain and/or possible skin loss. A minor systemic reactions can include shortness of breath, hives, nausea, vomiting and/or chills. A major reaction can include increased or decreased blood pressure, irregular heart rate, kidney failure, seizure, loss of consciousness or death. (In the event of a major reaction, our staff will place an immediate call to 911 and an ambulance will be summoned.)

Please ask any questions of our staff that you might have regarding your study today.

My signature below indicates that I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form. I have had the opportunity to discuss any concerns regarding my contrast administration with the technologist/radiologist. I acknowledge the possibility of an adverse reaction to a contrast injection. I give my consent to proceed with the injection and scan, as well as any blood tests necessary to help determine if my kidneys are functioning normally.

Signature (Parent or Guardian)

Date Signed: