Tuba City Regional Health Care Corporation
Radiology Department

Consent Form for Contrast Examination
Computed Tomography (CT)

Your physician, Dr. _____ has requested an x-ray examination, which will involve the injection of contrast material into your body through a blood vessel. The contrast flows through a small needle in your hand or inner arm. The possible minor side effects and complications include but are not exclusive of flushing of the skin, nausea, vomiting, itching, running nose and eyes, hives, sneezing and sweaty palms. More serious side effects occur less often and include spasm ("tightening" sensation) of the voice box or bronchial tubes, lowering of the blood pressure, chest pain, kidney problems and shock. On very rare occasions, death may occur.

Medications and personnel are here to treat any of these events. Your physician feels that the information from this examination outweighs the small risk of the study. Pre-medication with steroids and the use of non-ionic contrast minimize the risks. Please answer all of the following questions.

1. Have you had previous contrast study, such as kidney or blood vessel study? Yes No
   If yes, what type of study? _____
   Did you have any problem or difficulty with the injection? Yes No _____
   _____
2. Any history of allergy to iodine, foods, drugs or medications? Yes No
   If yes, to what substances are you allergic? _____
3. Do you have any history of: (please circle if YES)
   Hypertension Asthma Diabetes Seizures Tumors
   Kidney Disease Aneurysm Myeloma Heart Disease
4. Do you take Glucophage/Metformin? Yes No (Patient is to be off these medication for 48 hours after IV contrast administration). Check BUN and Creatinine to see if it has returned to baseline after the procedure.
   BUN _____ Creatinine _____ Date _____

FEMALES: Is there a possibility that you may be pregnant? Yes No
When was your last menstrual period? Date: _____

Technologist Use Only
Contrast Used/Volume: _____ Time of Injection: _____

Injection Site/Needle Site: _____ Technologist Signature: _____ Date/Time:_____

The examination has been explained to me including the benefits and alternative examinations. All questions have been answered to my satisfaction. I understand the above and consent to and agree with having this examination.

_____ _____
PATIENT Signature **Date &Time** **Witness** **Date & Time**

_____ _____
TRANSLATOR (If needed) **Date & Time** **LEGAL GUARDIAN Signature** **Date& Time**
(If patient is a minor {under 18}, or unable to give consent)

I have counseled this patient as to the procedure(s), attendant risks and expected results.

_____ _____ _____
PHYSICIAN Signature **Date & Time** **Name of Medical Facility**