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 you hand or inner arm. The possible minor side effects and complications include but are not exclusive of flushing of the skin, itching, running nose and eyes, sneezing and sweaty palms. More serious side effects are rare but could develop into a condition called Nephrogenic Systemic Fibrosis (NSF), also known as Nephrogenic Fibrosing Dermopathy (NFD).

Symptoms of these conditions include but are not limited to:

- Swelling, hardening, & tightening of the skin
- Reddened or darkened patches on the skin
- Burning or itching of the skin
- Yellow spots on the whites of the eyes
- Stiffness in the joints, problems moving or straightening arms, legs, or feet
- Pain deep in the hip bone or ribs
- Weakness of the muscle

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. Please answer all the following questions.

1. Have you had previous contrast study, such as kidney or blood vessel study? No Yes
   If yes, what type of study? _____
2. Did you have any problem or difficulty with the injection? No Yes
   _____
   _____
3. Do you have nay history of: (Please circle if YES)

   Hypertension Diabetes Kidney Disease Heart Disease

4. BUN _____ Creatinine _____ Date _____

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

_____

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 WITNESS Signature Date

_____ _____
TRANSLATOR (If Needed) Date LEGAL GUARDIAN Signature Date
(If patient is a minor (under 18), or unable to give consent.)

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

_____ _____ Sacred Peaks Health Center
PHYSICIAN Signature Date Name of Medical Facility

RADIOLOGY DEPARTMENT

Magnetic Resonance Imaging (MRI) Consent Form for Contrast Examination

Tuba City
Regional Health Care Corporation
167 North Main Street • P.O. Box 600
Tuba City, Arizona 86045 • (928) 283-2501

PATIENT INFORMATION