DIAGNOSTIC RADIOLOGISTS
PR NO 038 00 008400

medical imaging

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Ref: Rad/2011/31.1

CONSENT IODINATED CONTRAST INJECTION

PATIENT NAME : _____

1. Procedure: _____
2. The nature of this procedure is to inject an iodine containing dye into a vein to allow improved visualization and diagnosis.
3. I understand that the actual risk for an adverse reaction is small but may include nausea/vomiting, and/or an allergic reaction. In extremely rare cases a severe adverse reaction could occur that may in extreme cases lead to impaired or ceased breathing and/or circulation.
4. The SPECIFIC RISK of an adverse reaction can increase when particular pre-existing medical conditions or history is present. Please answer the following questions to the best of your knowledge.

- Have you ever received Iodinated Contrast in the past? YES ☐ NO ☐
  If yes, where, when and for what reason? _____
- Have you ever had an adverse or unusual reaction to Iodinated Contrast material? YES ☐ NO ☐
  If yes, please describe what happened. _____
- Do you have any of the following conditions?

Diabetes	___ YES	___ NO
Kidney Disease	___ YES	___ NO
Heart Disease/Failure	___ YES	___ NO
Cancer	___ YES	___ NO
Multiple Myeloma	___ YES	___ NO
Fever/Allergies	___ YES	___ NO
Asthma	___ YES	___ NO
Pheochromocytoma	___ YES	___ NO
Lung Disease	___ YES	___ NO

- Do you take Glucophage, Metformin, Avandamet, Metaglip, Glucovance, Actoplus, or Janumet? YES ☐ NO ☐

5. I CONSENT TO THE FOLLOWING: Diagnostic studies, X-ray examinations and other treatment relating to the diagnosis or procedures described herein.
6. By signing this form, I acknowledge that I've read or have had read this document and/or explained to me, that I fully understand its contents.

_____ _____
Patient's Signature (Relationship to patient, if patient is unable to sign)

_____ _____
Witness Date