HDI High Desert Imaging

INFORMED CONSENT FOR CAT SCAN (With or Without Contrast)

Patient Name:_____ MR#_____

IF YOU ARE PREGNANT OR THINK THAT YOU MAY BE PREGNANT, PLEASE INFORM PERSONNEL AT ONCE.

Your physician has requested that we perform a computerized tomography scan (CT) to obtain additional information. This is a diagnostic test that uses x-ray and a computer to produce images of internal body parts.

As part of your examination, we may need to inject you with a contrast solution containing iodine. This clear, colorless liquid is removed from your body by your kidneys and will not alter the appearance of your urine. It will show up on the images to provide important diagnostic information.

Soon after the injection you may experience a metallic taste and a warm sensation. You may feel some nausea. These feelings last only a short time.

Occasionally, minor allergic reactions occur in the form of itching, sneezing, hives, swelling of the eyes or wheezing. These symptoms may require treatment with medication we have on hand. It is very important that you inform the technologist if you experience any of the conditions mentioned in this form.

Rarely, a more serious reaction will occur. Even though it is extremely rare, medical statistics indicate that a fatality may occur from the injection of contrast. If you have had a reaction to a contrast injection previously or a history of asthma or other allergic conditions, any history of diabetes or any kidney disorder, anemia or sickle cell anemia, if you are taking Glucophage, are pregnant or breast feeding, you MUST inform the technologist.

Blood Laboratory results may be needed before we can perform this exam. If we are unable to obtain lab results from your physician that are no greater than 90 days old, we will require labs to be drawn and results forwarded to High Desert Imaging before your exam.

PLEASE INFORM THE TECHNOLOGIST IF YOU HAVE A HISTORY OF ALLERGIES, HAY FEVER, HIVES OR HAVE EVER HAD A REACTION TO A PRIOR INJECTION OF CONTRAST MATERIAL

Do you have Diabetes?	**YES / NO**	**Do you have a history of Liver disease?**	**YES / NO**
Do you have high blood pressure?	**YES / NO**	**Have you had a liver transplant?**	**YES / NO**
Do you have kidney disease?	**YES / NO**	**Have you ever had an injection of contrast for CT?**	**YES / NO**
If so, are you on dialysis?	**YES / NO**	**If so, did you have any problems?**	**YES / NO**
Do you have asthma?	**YES / NO**	**Do you have any allergies?**	**YES / NO**

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to me. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

Patient/ Parent / Legal Guardian Signature Date: Time

OFFICE USE ONLY

Contrast Material / Volume_____ _____ML

Injection site / Cath size_____ _____GA

Venipuncture Performed By_____

Tech Initials_____

Blood Creatinine_____

Date Obtained_____

Source of Values_____

Calculated GFR_____

Radiologist Notified ☐ YES ☐ NO