

CT/IVP

ANY PERSONAL HISTORY OF:

ASTHMA	Yes	No	KIDNEY DISEASE	Yes	No
DIABETES	Yes	No	BLADDER DISEASE	Yes	No
CANCER	Yes	No	HEART DISEASE	Yes	No
DIZZINESS	Yes	No	LIVER DISEASE	Yes	No
STROKE	Yes	No	MULTIPLE MYELOMA	Yes	No
SEIZURE DISORDER	Yes	No			
HEADACHES	Yes	No			
PROSTATE PROBLEMS	Yes	No			
ALLERGIC RESPIRATORY DISEASE	Yes	No			
CURRENTLY BREASTFEEDING			Yes	No	

If yes, please explain:

Are you currently taking Metformin Hydrochloride (Glucophage, Glucovance)? Yes/No
Did you take this medication today?

Yes/No

Have you ever had a previous reaction to x-ray contrast (dye)?

Yes/No

If yes, briefly describe your reaction:

Next appointment with referring physician:

Informed Consent for Computerized Tomography (CT) or Intravenous Pyelogram (IVP) with Contrast Injection:

Your physician has requested that we perform a CT or IVP to obtain additional information. This is a diagnostic test that involves X-Ray images and a computer to produce an image of internal body parts.

As part of your CT/IVP, a contrast agent will be injected into your vein via an IV catheter to produce better images of the part of the body being examined. This will assist the radiologist and your referring physician to obtain the optimal amount of information needed to diagnose your symptoms.

A small percent of patients may develop a reaction to contrast injection. **MINOR** reactions such as sneezing, red eyes, runny nose and itching may indicate a mild allergic reaction and is generally not life threatening. **MAJOR** reactions such as difficulty breathing, swollen tongue, generalized urticaria (itching) or shock, which are serious and may be life threatening and require emergency treatment. The risk of developing a **MAJOR** reaction is much less likely if you have not had problems with contrast injections in the past. Please inform the technologist and radiologist of any previous allergic reactions.

I (we) certify that I (we) have read this form or have had this form read to me and fully understand its contents. I (we) feel that I have been given sufficient information about my exam and the risks and hazards involved to give this informed consent.

Patient/Guardian Signature:

Date: