CT/IVP

ANY PERSONAL HISTORY OF:

YES	NO	ASTHMA	YES	NO	ALLERGIC RESPIRATORY DISEASE
YES	NO	DIABETES	YES	NO	KIDNEY DISEASE
YES	NO	CANCER	YES	NO	MULTIPLE MYELOMA
YES	NO	PROSTATE PROBLEMS	YES	NO	ARE YOU BREASTFEEDING AT THIS TIME?
YES	NO	DIZZINESS	YES	NO	HEART DISEASE
YES	NO	STROKE	YES	NO	LIVER DISEASE
YES	NO	SEIZURE DISORDER	YES	NO	BLADDER DISEASE
YES	NO	HEADACHES			

IF YES PLEASE EXPLAIN:

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Are you currently taking Metformin Hydrochloride (Glucophage, Glucovance)? Yes No
Did you take this medication today? Yes No
Have you ever had a previous allergic 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 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 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/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 give sufficient information about my exam and the risks and hazards involved to give this informed consent.

PATIENT/ GUARDIAN SIGNATURE	DATE

TECHNOLOGIST NOTES:

MEDICATION______________________ LOT#__________ EXP__________ VOLUME_______ cc TIME_______ BY_______

DEVICE ____________________ SITE: WNL_____ OTHER________ TECHNOLOGIST SIGNATURE________________________