

Informed Consent for Intravenous Contrast Media

You are scheduled for a computed tomogram (CT scan), or Intravenous Urogram (IVP) by your physician. This test uses x-rays to examine your body. Your doctor believes this test will provide information which should help us better understand and treat your problem.

As part of your examination, you will be given contrast media. This is injected in a vein while pictures are taken. While a safe drug, there may be some risk of reaction. The physician and staff are trained to treat these reactions if they occur. The types of reactions you might have are:

1. Minor reactions such as itching or an upset stomach usually requires no treatment. The chance of a minor reaction is about 1 in 10, or 10%.
2. Serious reactions: These side effects of contrast media usually require medical treatment and can cause harm. These include shortness of breath, irregular heartbeat, convulsions, kidney failure, or unconsciousness. The chance of a serious reaction is about 1 in 1,000, or 0.1%.
3. Death: Rarely, as with many drugs, contrast media can cause death. The chance of such complication is less than 1 in 100,000, or 0.001%.

If you have any questions, please ask the nurse, technologist or physician.

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THE NATURE OF THE PROPOSED PROCEDURE(S),

SIGNATURES

COUNSELING PHYSICIAN: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results. _____

(Signature of Counseling Physician)

PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) to be performed.

(Signature of Witness) **X** _____ Date: _____
(Signature of Patient)

SPONSOR/GUARDIAN: I, _____, sponsor, guardian of _____, understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

(Signature of Witness) _____ Date: _____
(Signature of Sponsor)

(Relationship) _____
(Name of Patient)

Staff use only

Allergy (medication) Diabetes General Condition Asthma Cardiac disease Hypertension Pulmonary