ENVISION
MEDICAL IMAGING

INFORMATION & CONSENT FORM

CONTRAST MEDIUM - INTRAVENOUS

Introduction

The scan your doctor has asked us to perform may require the injection of contrast medium. This is a medical dye used to allow or improve detection of abnormalities in the body. The intravenous contrast is iodine based.

If you have any allergies to X-ray dye or iodine, please inform the staff member prior to commencing the scan.

Please ask questions about anything on this form that you do not understand.

Risks and side effects

As with most drugs, side effects and adverse reactions are possible. These may occur during or after the procedure.

Side effects associated with the procedure may include a feeling of warmth or a metallic taste in the mouth. Occasionally side effects such as nausea or rash *(hives)* may occur. More severe allergic reactions may result in shortness of breath and facial swelling. It is extremely rare for reactions to be life threatening.

I have read the information provided regarding my procedure. I understand the information and have had the opportunity to ask questions about what is going to happen, the reasons for the procedure being performed, and the associated risks. I agree to have the procedure performed.

To further reduce the risk of an adverse reaction it is important that you answer the following questions. Please circle your response and answer all questions this page.

Question			YES	NO
Have you previously had an injection of X-ray contrast?			YES	NO
*If **YES**, did you have an adverse reaction to the X-ray contrast?*			YES	NO
Do you have any known **Allergies?** *e.g. Iodine*			YES	NO
If YES, please list				
Do you take **diabetic tablets?**			YES	NO
If YES, are you on Diabex, Diaformin, Glucohexal, Glucomet, Glucophage, Glucovance, Novomet, Avandamet				
Do you have poor kidney function?			YES	NO
If YES, date:	*eGFR*	*Creatinine level*		
Do you have **Asthma?**			YES	NO
Are you on blood thinning medication? *e.g. Warfarin, Plavix, Aspirin*			YES	NO
Have you used **Viagra**, **Cialis**, or a **similar drug** in the last 48 hours?			YES	NO
Have you had any **heart surgery**? (*i.e. Stents, Bypass*) Give details:			YES	NO
Do you take any blood pressure or heart medication?			YES	NO
If YES, please list				
Weight *(kg)*	Height *(cm)*			
FEMALE PATIENT ONLY: Is there any chance you may be pregnant?			YES	NO

Patient Name		
Patient Signature *(or signature of legal guardian)*		Date
Signature of MIT / Radiologist		

PATIENT ID CHECKLIST

NAME confirmed ☐ DOB confirmed ☐ GENDER confirmed ☐ ADDRESS confirmed ☐

PROCEDURE CHECKLIST

TYPE confirmed ☐ SIDE confirmed ☐ CONSENT confirmed ☐ TIME OUT ☐

NO CO2