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.

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

| | | |
|---|---|---|
| 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?** | YES | NO |
| *If **YES**, please list:* | | |
| Do you have **Asthma?** | YES | NO |
| Are you willing for your de-identified scans to be used for research and educational purposes? | YES | NO |
| Are you currently taking **Metformin**? *Medications containing Metformin: Diabex, Diabex XR, Diaformin, Diaformin XR, Formet, Glucobete, Glucovance, Janumet, Metex XR.* | YES | NO |

Do you have any of the following: If **YES** please tick ☑

Diabetes ☐ Kidney Disease or transplant ☐ Current dialysis ☐

If **YES,** to any of the above:
Date: eGFR: Creatinine level:

Do you have any of the following: If **YES** please tick ☑

Over or under active thyroid ☐ Possible or confirmed thyroid cancer ☐ Currently taking thyroid medication ☐

Myaesthenia Gravis ☐ Sickle Cell Disease ☐ Currently taking beta blocker medication ☐

| | |
|---|---|
| Height *(cm)* | Weight *(kg)* |

| | | |
|---|---|---|
| **FEMALE PATIENTS ONLY: Is there a chance you might be pregnant?** | YES | NO |

*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.*

| | |
|---|---|
| **Patient Name:** | Date: |
| **Patient Signature:** (*or signature of legal guardian*) | Previous Imaging: |
| Signature of MIT: | Signature of MIA / Nurse: |

**OFFICE USE ONLY** **Signature of EMI Staff** _____

**PATIENT ID CHECKLIST**
NAME confirmed ☐ DOB confirmed ☐ GENDER confirmed ☐ ADDRESS confirmed ☐

**PROCEDURE CHECKLIS**
TYPE confirmed ☐ SIDE confirmed ☐ CONSENT confirmed ☐