HOMER GLEN IMAGING

Name:_____
ID#_____
Date:_____Time:_____

CONSENT FOR CONTRAST MEDIA TESTS AND PROCEDURES

1. I acknowledge that I have been specifically asked the following information and I understand that it is very important for me to give complete and accurate answers to these questions:
   - Procedure to be performed:_____
   - Reason for procedure:_____
   - Are you pregnant? ❑ Yes ❑ No Date of last menstrual cycle _____/_____/_____
   - Are you diabetic, have asthma, hay fever, sickle cell disease, myeloma or known thyroid disease? ❑ Yes ❑ No
   - Are you allergic to any drugs, food, or have you had any reactions to previous injections of contrast media used for X-Ray procedures? ❑ Yes ❑ No
   - Are you on any medications (i.e. Glucophage, Metformin, etc), including non-prescription drugs? ❑ Yes ❑ No

   IF YOUR ANSWER TO ANY OF THE ABOVE QUESTIONS IS YES, YOU HAVE A HIGHER RISK THAN NORMAL TO AN ADVERSE REACTION OF CONTRAST MEDIAS IN THE TESTS WHICH ARE TO BE PERFORMED
2. The most common adverse reactions to the use of contrast solutions are usually mild an transient, although severe and life-threatening reactions have occurred. The usual reactions, if there are any reactions at all, are nausea, vomiting, flushing, or a generalized feeling of warmth. Symptoms such as chills, fever, sweating, headache, dizziness, weakness, choking, wheezing, a rise or fall in blood pressure, ventricular fibrillation, cardiac arrest, rash, edema, cramps, etc., may occur. The benefit of the exam may outweigh the risks and/or complications of potential kidney damage and decreased kidney function due to contrast injection and these risks and/or complications have been explained to me. I understand I have the right to change my decision or revoke consent for any medical treatment or procedure.
3. I hereby consent to permit the administration of contrast solutions as deemed necessary or appropriate by my physician or any member of the staff of the IMAGING CENTERS OF AMERICA **.**

_____ _____
PATIENT'S SIGNATURE DATE

_____ _____
SIGNATURE OF AUTHORIZED REPRESENTATIVE DATE

_____ _____
SIGNATURE OF PERSON OBTAINING CONSENT DATE

RADIOGRAPHIC CONTRAST ADMINISTRATION ASSESSMENT

Access obtained in Radiology department: ❑ Yes ❑ No

Location of IV _____

❑ IV Cathlon D/C with tip intact, all bleeding controlled at time of discharge from department. If not please document:

_____

Contrast used:
- ❑ Omnipaque 350
- ❑ Visipaque 320
- ❑ Omniscan
- ❑ Gastrograffin
- ❑ Barium
- ❑ Other _____

Amount Administered:_____

❑ Patient's condition unchanged after completion of exam. If not please document:

❑ Patient education given.

Signature date/time: _____