IMAGING CONSENT FORM

Patient Name: __________________________________ DOB: ____________ Height: ____ft ____in Weight: _____lbs

Have you had a previous scan of this area? Y|N If yes, when and where? ____________________________

Have you had surgery on this area before? Y|N If yes, type and when? ______________________________

It is important that we identify metals or other implanted objects in your body. Some can be harmful to you during your exam and others simply cause an artifact on our images without posing a hazard.

Circle YES or NO if you have any of the following:

Pacemaker/Defibrillator	YES	NO	Body Piercings	YES	NO	Headaches	YES	NO	Slurred Speech	YES	NO
Aneurysm Clips	YES	NO	Recent Endoscopy Procedure	YES	NO	Neck or Back Pain	YES	NO	Memory Loss	YES	NO
Neurostimulator	YES	NO	Prosthesis	YES	NO	Prior Stroke	YES	NO	Hearing Loss	YES	NO
Bullets, BBs	YES	NO	Joint Replacement	YES	NO	Numbness or Weakness	YES	NO	Vision Loss	YES	NO
Shrapnel, Metal Fragment	YES	NO	Medicine Patch/Pain Patch	YES	NO	Multiple Sclerosis	YES	NO	Arm Pain	YES	NO
Shunt or Stent	YES	NO	Penile Implant	YES	NO	Dizziness/Loss of Balance	YES	NO	Leg Pain	YES	NO
Tissue Expander	YES	NO	Metal Fragments in Eyes	YES	NO	Seizures	YES	NO	Difficulty Walking	YES	NO
Nerve or Bone Stimulator	YES	NO	Eye Implant	YES	NO	Blackouts	YES	NO	Swelling	YES	NO
Insulin or Morphine Pump	YES	NO	Cochlear Implant	YES	NO	Confusion	YES	NO	Breast Feeding	YES	NO
Heart Valve	YES	NO	Hearing Aid	YES	NO	Blurred Vision	YES	NO	Pregnant	YES	NO

CONTRAST

Patients over 60 years of age or with a history of diabetes or kidney disease require recent blood work to determine their creatinine level prior to injection of contrast material.

________ **CT Contrast**

Your physician has requested a CT scan with contrast. The injection will be given into a vein in your arm or hand. For certain CT exams a contrast media is injected into your bloodstream to show how organs are functioning or to visualize certain structures in your body. The use of intravenous contrast will help provide better vascular opacification and tissue contrast during your examination thereby providing more information in helping us evaluate your problem. The contrast agent "omnipaque" is iodine based. The technologist also needs to know of any previous adverse reactions to iodine, contrast material, bee stings, shrimp, or shellfish.

Have you ever had a CT with contrast material injected into your veins? Y / N If yes, were there any problems? ___________________

________ **MRI Contrast**

Your physician has requested a MRI examination with contrast. The injection will be given into a vein in your arm or hand. For certain MRI exams a contrast media is injected into your bloodstream to show how organs are functioning or to visualize certain structures in your body. The use of intravenous contrast will help provide better vascular opacification and tissue contrast during your examination thereby providing more information in helping us evaluate your problem. The contrast agent "gadolinium" is a water base substance which is NOT iodine.

Have you ever had an MRI with contrast material injected into your veins? Y / N If yes, were there any problems? ________________

________ **Arthrogram**

Your physician has requested that you have a MRI/CT examination with contrast after an injection in your joint.

Do you have a history of:

Asthma Y N	Kidney Failure Y N	Kidney Disease Y N	On Dialysis Y N	Diabetes Y N
Kidney Removal Y N	Sickle Cell Anemia Y N	Any allergies Y N	If yes, list: ____________________________	

Please list medications you are currently taking:

____

The purpose of this form is to ensure that you are informed about this procedure and of its possible side effects and complications. I hereby certify that I have read and fully understand my signature represents authorization for this exam.

___________________________________ _______________________

Signature of Patient Date

CONTRAST REFUSAL

I do not consent to the contrast exam as ordered by my physician, I acknowledge that the exam may not be as accurate as it would have been if I consented to contrast administrations.

___________________________________ _______________________

Signature of Patient Date

OFFICE USE ONLY

Date & Time of Injection________________ Injection Site__________________Type & Amount______________ Tech Initials______________