Radiology Medical Group of Santa Cruz County, Inc.
Assessment for CT IV Contrast Injection

Patient name: _____ MRN#: _____

Your physician has referred you for a Computerized Tomographic examination. Your study requires the use of an intravenous contrast injection which will enhance your organs on the images. The contrast injection is similar to those used in an examination of the kidneys called Intravenous Pyelography (IVP) and Angiography. Depending upon the rapidity with which the solution is injected, you may or may not experience a metallic taste or warm flush sensation over the body. The feeling is transient in nature and typically lasts for about 45 seconds.

There are some minor side effects which can also occur. During the injection or shortly thereafter, you may experience nausea for a few seconds. Less frequently you may have a minor allergic-type of response (itching or hives). Other minor allergic responses that are more unusual can occur (1 in 2,000) such as sneezing, swelling of the eyes, lips and or difficulty breathing. We have medications to treat these problems quickly.

There are more serious complications, which are very rare, but can also occur. Complications such as circulatory collapse, respiratory arrest, and shock can happen (1 in 14,000). These complications may progress to a fatality in approximately one out of 50,000 to 75,000 cases despite rigorous therapy. Again these are very rare complications.

Your physician is aware of the remote possibilities of a complication and feels that the information obtained outweighs the potential risk of the procedure. If you wish to discuss any aspects of this exam, the Radiologist will be happy to answer any of your questions.

Height: _____ Weight: _____ Age: _____

Answer the questions below, please state Yes or No.

-Are you pregnant or breastfeeding? _____
-Asthma? _____
-Known allergy to Iodine or any IV contrast? _____
-Personal history of kidney disease? _____
-Family history of kidney failure? _____
-Insulin-dependent diabetes of 2 years or greater? _____
-Non-insulin dependent diabetes of over 5 years duration? _____
-Are you currently taking Glucophage/Glucovance/Metformin? _____
-Multiple myeloma or sickle cell disease? _____
-Prior contrast history (IVP, Angiography, prior CT)? _____

Please list any food or medicine allergies:_____

I have carefully read and understood the above and give my consent for intravenous injection of contrast solution. I have discussed any questions I have with my physician or radiologist.

Signature of Patient: _____ Date: ___/___/_____

Witness/Guardian: _____

FOR OFFICE USE ONLY:
Date of Lab draw:
Creatinine:
Notes:
Contrast: Volume: Lot: Exp Date:
Location:
Notes:

Technologist initials: _____ Radiologist signature (if required): _____