MIDDLETOWN MEDICAL
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CT INTRAVENOUS CONTRAST
PATIENT EDUCATION / CONSENT FORM

Your doctor has requested a radiology examination that requires an intravenous contrast injection. The contrast material used is an iodine containing solution that circulates through the blood stream. This allows the blood vessels of the brain and body to be better visualized. The contrast is then collected by the kidneys, urinary tract and bladder. The contrast is urinated out of your body within a few hours.

Most patients experience no unusual effects from this injection. Occasionally the patient may experience a warm sensation, nausea or vomiting. As with any procedure, however, a few risks are involved. A small number of patients have a mild allergic-type reaction, such as swelling of the eyes and lips, sneezing or difficulty breathing. In most circumstances, the risk of a reaction is very small. The risk is somewhat greater in asthmatics and patients with multiple allergies. If you are asthmatic or highly allergic to any food or medication, please inform the radiologist. You should have been pre-medicated prior to the exam (with a steroid such as prednisone).

Serious or life threatening contrast reactions are extremely rare. Naturally, medications are on hand to treat these conditions, should they occur. Your doctor is aware of these possible complications but has determined that the additional diagnostic information provided by the contrast outweighs the minimal risks of this procedure.

The radiologist or designee will be happy to answer any specific questions you may have about the procedure, either before or at the time of the study.

I,_____, understand the procedure and give permission for the scan to be performed and for the contrast material to be used if necessary.

Patient Signature: _____ Date: _____

Patient Date of Birth: _____

Witness Signature: _____ Date: _____

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Visit us on the web ***www.middletownmedical.com***

CT SCAN CONTRAST INJECTION
HISTORY AND QUESTIONNAIRE

Patient Name: _____ Date of Birth:_____

Exam Date: _____ What are we scanning today?_____

Have you ever had a study done for this problem at this facility before?____YES____NO

Have you ever had a CT scan done at another facility? If so, where?_____

Have you ever had an intravenous contrast material (I.V. X-RAY DYE) before?_____YES_____NO

If yes, did you have an abnormal or allergic reaction? _____YES_____NO

If you had an allergic reaction, did you require treatment? _____YES_____NO

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING: (if so, please give brief explanation)

YES	NO	
□	□	ALLERGIES/HAY FEVER_____
□	□	LUNG DISEASE/ASTHMA/COPD_____
□	□	CANCER_____
□	□	HIGH BLOOD PRESSURE_____
□	□	DRUG ALLERGY/FOOD ALLERGY_____
□	□	DIABETES_____
□	□	KIDNEY DISEASE/KIDNEY SURGERY_____
□	□	ANURIA (INABILITY TO URINATE)_____
□	□	THYROID DISEASE_____
□	□	MULTIPLE MYELOMA_____
□	□	SICKLE CELL DISEASE/TRAIT_____
□	□	BLOOD DISORDERS/LEUKEMIA_____
□	□	LATEX/ADHESIVE ALLERGY_____

Please list all medication you take: _____

_____

Are you taking glucophage, metformin, glucovance, glucophage XL, advandamet, janumet, or metaglip?
_____YES_____NO

Females: Any chance of pregnancy? _____YES_____NO Date of last menstrual cycle_____

Do you have an appointment for a thyroid uptake and/or pancreas study utilizing nuclear radioisotopes within the next 30 days?
_____YES_____NO

PATIENT SIGNATURE DATE