

COLUMBUS CIRCLE IMAGING

A division of West Side Radiology Associates, P.C.

1790 Broadway New York, N.Y. 10019 .Tel :(212) 977-4100

CT Consent Form

Name: _____

Date: _____

Your doctor has asked that a CT Scan be performed using intravenous contrast material. This is an iodine containing solution that aids in the visualization of your organs and blood vessels, which helps in the diagnosis of pathology in various parts of your body. In order for us to administer this “dye” you must be informed of the possible risks involved.

_____ I have read the above and understand it all.

After injection of the intravenous contrast, most patients feel a sensation of warmth, a funny metallic taste in their throat, transient nausea and a feeling of warmth in the groin. Some patients develop hives and itching, but this is self-limited and rarely needs to be treated with antihistamines. 1 in 500 patients may develop a severe reaction and 1 in 5,000 may have a life threatening reaction, all of which may have to be aggressively treated with medications. These reactions may involve; tightness in the throat; facial swelling; difficulty breathing; drop in blood pressure or even a seizure. Generally speaking, intravenous contrast is extremely safe and well tolerated and these reactions are rare.

_____ I have read the above and understand it all.

This attached questionnaire will help us to decide other issues concerning the contrast material, including whether or not you should have it at all. If you have any questions; you will be able to speak to the supervising radiologist. When your questions have been answered or if you do not have any questions, please sign the form below.

_____ I have read the above and understand it all.

Patient Signature: _____

Date: _____

Witness: _____

Interpreter: _____

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Name: _____

Date: _____

Have you ever had a **CT Scan** before?

Yes No I don't know

If yes, **did** you have any medical complications (e.g. allergic reaction) and what were the complications? _____

Have you had a test using an injection of dye in the vein to study any part of the body (e.g. kidneys)?

Yes No I don't know

If yes, did you have any medical complications (e.g. allergic reaction) and what were the complications? _____

Do you have any severe allergic reactions to anything including food, medicines or animals?

Yes No I don't know

If yes, what kind of food or medicines? _____

What were the reactions you have experienced? _____

Did you have any difficulty breathing or swelling of the face and throat?

Yes No I don't know

Do you have asthma?

Yes No I don't know

If yes, have you ever been admitted for an asthma attack?

Yes No I don't know

Have you ever had a tube inserted down throat to help you breathe?

Yes No I don't know

"Have you ever used any asthma medications or inhalers?"

Yes No I don't know

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Are you a diabetic?

Yes No I don't know

If yes, do you take any medication for your diabetes?

Yes No I don't know

If yes, please list the medications: _____

Do your kidneys work normally?

Yes No I don't know

If no, please explain: _____

Is there any chance that you might be pregnant?

Yes No I don't know

Have you ever had surgery?

Yes No I don't know

If yes, please indicate what type of surgery _____

Have you ever had chemotherapy?

Yes No I don't know

If yes please indicate the start date: _____ Completion date: _____

Have you ever had radiation therapy?

Yes No I don't know

If yes please indicate the start date; _____ Completion date; _____