Patient Sticker

_____

Appomattox Imaging
HCAVa
AN HCA AFFILIATE

CT CONTRAST CONSENT

Your physician has referred you for an examination that requires you to receive an injection of a non-ionic contrast material into a vein. Minor allergic reactions such as hives, swelling, itching, or skin rash are rare but may occur. We recommend that you notify your primary care provider should you experience any type of contrast reaction. These reactions may require medications, but will usually disappear within a few minutes of the injection. More serious allergic reactions, such as anaphylactic shock, are rare occurrences and medication is readily available to treat these conditions.

It is important that you drink large amounts of fluids in the next 24 hours to flush the contrast through your kidneys. Please inform the technologist if you are on medication for diabetes, if you have any allergies, if you have asthma, have kidney disease, have anemia or disease that affect the red blood cells, if you are pregnant, breastfeeding, or if you have had a prior reaction to the contrast material used for these studies.

PLEASE ANSWER THE FOLLOWING:

Yes_____ No_____ Were you prescribed any special pre-medication for today's study other than the liquid we may have given you to drink?

Yes_____ No_____ Have you had contrast media (e.g. X-Ray Dye) before?

Yes_____ No_____ Did a contrast reaction occur during a previous exam in CT or MRI?
If Yes, please explain _____

Yes_____ No_____ Have you had anything to eat in the last 4 hours?

Yes_____ No_____ Do you take diabetes medication?
If Yes, technologist will review medication(s) with you.

Yes_____ No_____ Are you on dialysis?

Yes_____ No_____ Are you breast-feeding?

Yes_____ No_____ Do you have general allergies (hay fever, dust, mold, dander, food)?

Yes_____ No_____ Do you have any drug allergies? Please list: _____

I have read and understand the above information. I have had my questions answered to my satisfaction and give my consent to have the exam performed. I understand that in spite of every skill and effort made to avoid complications during the examination, occasional complications do occur. I understand that I have the right to refuse any portion of this procedure.

Patient/Representative Signature _____ Date_____

If not the patient, please indicate relationship _____

Reviewed By (Technologist Signature): _____

TECHNOLOGIST TO COMPLETE THIS SECTION

Creatinine _____ eGFR _____ ☐ No Contrast given per eGFR

Contrast Injection Time: _____

Contrast Agent: _____ Lot # _____ IV Started By: _____

_____ Hand Injection: Volume Used _____ ml IV Site: _____

_____ Injector: Volume Used _____ ml IV Gauge: _____

Waste_____ ml IV DC'd By: _____

Technologist: _____

Contrast Reaction _____ No _____ Yes Radiologist on site:_____