Patient Sticker

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Independence Park Imaging
HCAVA
AN HCA AFFILIATE

MRI CONTRAST CONSENT

Your physician has referred you for an examination during which you will receive an injection of Gadolinium contrast material into a vein. Adverse reactions can occur in up to 2.4% of patients. The most common reactions are nausea, headache, dizziness, rash and hives. These reactions are generally transitory and abate within 24 hours. More serious sensitivity reactions, such as anaphylactic shock, are rare occurrences and medication is readily available to treat these conditions. There is an extremely rare complication called Nephrogenic Systemic Fibrosis (NSF) that has been reported with MR Contrast in patients who have a history of Renal Failure, particularly those who require dialysis. Please notify your technologist if you have any history of kidney disease. There is currently no known risk for this disease in the absence of kidney disease. We recommend that you notify your primary care provider should you experience any type of contrast reaction.

Please notify the technologist if you are pregnant, breast feeding, have liver or kidney disease, or have anemia or diseases that affect the red blood cells. Any previous reactions to MRI contrast material or other medications should also be reported before injection. While this information may concern you, we believe it to be in your best interest to be informed and to understand what is involved. Naturally, you may refuse permission to perform this test or you may change your mind before the procedure. It is worth knowing that the risk of any serious complication is extremely small.

PLEASE ANSWER THE FOLLOWING:

Yes_____ No_____ Were you prescribed any special pre-medication for today's study?
If Yes, name of medication_____

Yes_____ No_____ Do you have Asthma or Emphysema?

Yes_____ No_____ Have you had MRI IV contrast media before? If Yes, how many? _____

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

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: _____

Yes_____ No_____ I have received a Multihance / Prohance Patient Medication Guide for review.

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

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: _____