STATEMENT OF CONSENT FOR COMPUTERIZED TOMOGRAPHY (CT)

Date:_____ Weight: _____

Name (legal):_____ Date of Birth: _____

Exam/Scan: _____

A Computerized Tomography (CT) scan is an X-ray that produces detailed images of the body axial cuts. I understand that a contrast IV administration (Iodine) **may** be necessary in order to improve the visualization of those areas of interest and it may carry some risk. My doctor is aware of these risks and has determined that the benefit in diagnostic information, which may be obtained from the injection of contrast material, would be beneficial. In this procedure, a needle is introduced into one of your blood vessels that is usually placed in the arm. Through this needle, a solution will be injected which will enable us to see an area of interest on CT scans.

I understand that usual complications, which we would consider relatively minor, but nevertheless can be distressing to patients, are a metallic taste in the mouth and a warm flush. Sometimes, a patient may have hives or itching. There are less frequent complications, which we consider more serious, such as an asthmatic attack, convulsions or shock. It would be impractical and probably misleading to the average person to describe in detail all the complications, which might possibly result from this procedure.

Have you ever had an exam where you had radiographic contrast material injected into your veins or arteries? ☐ Yes ☐ No

If yes, any complications _____Date of exam_____

Any Allergies ☐ Yes ☐ No If yes, please list _____

Please Mark Below:

Are you taking any of these medications?

Glucophane, Glucovance or Metformin ☐ Yes ☐ No

Do you have any history of?

Myeloma ☐ Yes ☐ No

Heart Failure ☐ Yes ☐ No

Kidney Disease ☐ Yes ☐ No

Asthma or Hay Fever ☐ Yes ☐ No

Diabetes ☐ Yes ☐ No

If female, Pregnant? ☐ Yes ☐ No

If yes how far along_____

Last Menstrual Period (L.M.P): _____

Privacy Policy: I understand that the results of my study are confidential and will be disclosed only to my referring physician. A written "release of medical records consent" must be signed by me if I would like my results to be provided to additional physicians other than my direct referring physician.

Certification: I certify and understand that I personally completed this form and that all above information contained above is true, correct and complete to the best of my knowledge.

Patient or Guardian signature_____ Date_____