*For Partners Use*

MRN #

**INFORMED CONSENT FOR CONTRAST INJECTION**

Patient ________________________________________ Date _____________________

Type of Exam ____________________________________________________________

I hereby authorize the Supervising Radiologist and/or qualified Technologist to administer an injection of contrast medium for the purpose of enhancing body organs and vascular structures for a more complete diagnostic study.

I have been made aware that it is possible to experience an allergic-type reaction to the injection. The most common reactions include nausea, vomiting, flushing or a generalized feeling of warmth. Other reactions include hives, chills, fever, sweating, headache, dizziness, weakness, severe itching, sneezing etc. I understand that an adverse reaction is usually mild and transient, although life threatening reactions have occasionally been reported. For this reason, I understand that well trained personnel are available to treat me in the event of a serious reaction.

Notify the Technologist and/or Radiologist before signing, if you are taking Glucophage for Diabetes, or if you have any of the following conditions : sickle cell disease, multiple myeloma or pheochromocytoms.

I authorize the above to administer any additional medications or treatment deemed necessary to aid in the relief of any reaction.

I have read and understand the above and agree to the injection of contrast medium.

____________________________________________ Date ____________________
Patient / Guardian / Parent Signature

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Relationship to Patient