CONSENT TO USE AN IODINATED CONTRAST AGENT

Your doctor has requested an examination which may require that you receive an injection of a contrast agent into a vein. The contrast agent is a clear solution, sometimes called “x-ray dye” because of its effects on the pictures that are taken. Injections of this type are given in hospitals to allow the radiologist to see abnormalities that might not otherwise be visible. The clear dye will be passed unnoticed through the kidneys within 24 hours.

Most people have this type of examination without any complications; however, mild to moderate reactions to the contrast agent occur occasionally. Mild reactions could include nausea, vomiting, itching and hives. Moderate reactions could include changes in blood pressure, shortness of breath, seizure and kidney damage. These reactions may pass without treatment or respond quickly to medication. In patients with significant kidney disease, the dye could cause your kidneys to stop working for a period of time. In situations involving any risk factors, contrast agents are only used if the potential benefit outweighs the risk.

As with any medication, in very rare circumstances (1 in 170,000 people) a severe reaction can occur including: cardiac arrest or even death. There is no test to warn us in advance of this rare reaction.

During injection of the contrast agent, it is common to experience a metallic/funny taste in your mouth, a warm sensation or hot flush and/or a sensation of wetting yourself. These side effects are harmless and should only last 30-45 seconds.

USE IN PREGNANCY:
Contrast agents should not be used during pregnancy unless the potential benefit to the mother clearly justifies the potential risk to the fetus.

Written consent is required for this procedure and will be documented in our computer. You are not required to give your consent until you are satisfied that you are informed about the test and you understand the risks. Please ask the technologist any questions you have about the examination. If the technologist is unable to answer your questions, they will consult a Radiologist.

Revised June 2020

Questions for Patients having a CT

Please answer these routine questions to the best of your ability. Your answers will give the radiologist (a doctor who looks at x-ray images) additional information they need to prepare your CT report. If you have any questions or need help completing this form, please ask the CT technologist.

Name: _____

Weight: _____ Height: _____

Is there any chance of pregnancy? ☐ Yes ☐ No

SECTION A:

Have you ever smoked **tobacco** products? ☐ Yes ☐ No

Examples include cigarettes, cigars, pipes, etc. Do not include e-cigarettes.

If yes

How many years in total? _____

Have you smoked in the last 15 years? ☐ Yes ☐ No

Answer one of the following:

Average number of cigarettes/cigars each day _____

Average number of cigarettes/cigars each week_____

Average number of packs each day _____

Average number of packs each week _____

Have you or your spouse ever worked with asbestos? ☐ Yes ☐ No

For example- plumber, pipe fitter, ship builder, construction, demolition, mechanic etc.
This does not include living in a home or working in an office with asbestos.

Has any one in your immediate family had cancer that started in the lungs? ☐ Yes ☐ No

This includes your biological father, mother, brother or sister. ☐ Do not know

Have you ever had any type of cancer? ☐ Yes ☐ No

If yes, what type? _____

For example-colon, lung, breast,lymphoma, melanoma etc

Have you had radiation therapy to your chest? ☐ Yes ☐ No

For example- for lung or breast cancer or lymphoma

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SECTION B:

Do you have inflammatory bowel disease? *Such as Crohn's or Ulcerative Colitis*	☐ Yes	☐ No
Do you or have you ever had cancer?	☐ Yes	☐ No
*Please specify type:*_____		
Did you receive chemotherapy?	☐ Yes	☐ No
If yes, when? _____		
Did you receive radiotherapy?	☐ Yes	☐ No
If yes, when? _____		
Have you had any previous surgeries?	☐ Yes	☐ No
Please specify:_____		
_____		
Do you have HIV/AIDS?	☐ Yes	☐ No

SECTION C:

Have you ever had x-ray dye?	☐ Yes	☐ No
If yes, did you have a reaction? _____		
Do you have any drug allergies?	☐ Yes	☐ No
Please specify_____		
Do you have asthma or another breathing disorder?	☐ Yes	☐ No
Are you a diabetic?	☐ Yes	☐ No
If yes, are you taking Metformin/Glucophage?	☐ Yes	☐ No
Do you have kidney disease?	☐ Yes	☐ No
Do you have liver disease? Including hepatitits	☐ Yes	☐ No
Are you breast feeding?	☐ Yes	☐ No

I agree to the use of a contrast agent for my CT Scan.

Signature:_____ Date:_____

For staff use:

Amount: Rate: Gauge/location: