WINN ARMY COMMUNITY HOSPITAL
Department of Radiology
Request and Consent for Iodinated Contrast Injection

DO NOT SIGN THIS FORM UNTIL YOU HAVE READ AND FULLY UNDERSTAND ITS CONTENTS

PATIENT EXAM LABEL/NAME:

THE FOLLOWING HAS BEEN EXPLAINED TO ME IN GENERAL TERMS AND I UNDERSTAND THAT:

1. The diagnosis requiring this procedure is ____ .

2. The nature of this procedure is to inject an iodine containing dye into a vein to allow improved visualization of organs and blood vessels and improve detection and characterization of any abnormalities.

3. The purpose of this procedure is to: ____ .

4. MATERIAL RISKS: The actual risk for an adverse reaction is small but may include a local infection/inflammation at the injection site, nausea/vomiting, and/or a mild allergic reaction manifested by hives or itching. Rarely, a moderate or severe adverse reaction could occur that leads to loss of or function of any limb or organ, an allergic reaction that impairs breathing or circulation and could lead to cardiorespiratory arrest/heart damage/brain damage/paraplegia or quadriplegia or death.

5. The SPECIFIC RISK of an adverse reaction can increase when particular pre-existing medical conditions or history is present. Please answer the following questions to the best of your knowledge.

a. Have you ever received Iodinated Contrast in the past? _____ YES _____ NO
If yes, where, when and for what reason? ____

b. Have you ever had an adverse or unusual reaction to Iodinated Contrast material? _____ YES _____ NO
If yes, please describe what happened.

c. Do you have any of the following conditions?

Diabetes	_____ YES	_____ NO
Kidney Disease	_____ YES	_____ NO
Heart Disease/Failure	_____ YES	_____ NO
Cancer	_____ YES	_____ NO
Multiple Myeloma	_____ YES	_____ NO
Fever/Allergies	_____ YES	_____ NO
Asthma	_____ YES	_____ NO
Pheochromocytoma	_____ YES	_____ NO
Lung Disease	_____ YES	_____ NO

d. Do you take Glucophage, Metformin, Avandamet, Metaglip, Glucovance, Actoplus, or Janumet? _____ YES _____ NO

e. Please list all current medications you are taking?

6. I CONSENT TO THE FOLLOWING: Diagnostic studies, test, anesthesia, x-ray examinations and other treatment relating to the diagnosis or procedures described herein.

7. By signing this form, I acknowledge that I have read or have had read and/or explained to me, that I fully understand its contents and that I have been given ample opportunity to ask questions and any questions have been answered satisfactorily. All blanks and/or statements requiring completion were filled in and all statements I do not approve of were stricken before I signed this form.

8. I acknowledge that I selected Winn Army Community Hospital as my treatment facility and I hereby voluntarily request and consent to the performance of the procedure described or referred to herein by the staff of Winn Army Community Hospital together with any other physician(s) or non-physician(s) designated or selected by it.

9. A physician is available to discuss the risks/benefits of this procedure in more detail or to answer any other questions related to this examination that you might have. Would you like to speak with a physician at this time? _____ YES _______ NO

10. The following questions are for the medical staff performing this procedure?

a. The possibility of success for the above procedure is _____ good _____ fair _____ poor
b. Practical alternatives to this procedure include:
c. If the patient chooses not to have the above procedure(s), the prognosis is:

______________________________ Patient's Signature

______________________________ (Relationship to patient, if patient is unable to sign)

______________________________ Witness

______________________________ Date