PARTNERS
IMAGING CENTERS

INFORMED CONSENT FOR CONTRAST INJECTION

Patient Name _____ Date _____

Type of Exam _____ Account # _____

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 comment 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 adverse reaction usually mild and transient, although severe life-threatening reactions have occasionally been reported. For this reason, I understand that well-trained personnel are available to treat me in the even of a serious reaction.

Notify the Technologist and/or the 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.

Patient / Guardian / Parent Signature _____ Date _____

Relationship to Patient _____