

IMAGING STUDY WITH IV CONTRAST – INFORMED CONSENT

REV. 11/12/2015

Informed Consent

Your medical provider has / has not (circle one, initial:____) requested an exam that will require the use of iodine contrast. The contrast (dye) will be administered into your body through an intravenous (IV) injection. The IV contrast is filtered through the kidneys and eliminated through urination. The information gained from this test will help your provider diagnose your problem but will not treat you or make you well.

During the injection, you will feel some sensations as the contrast goes through your blood vessels. These sensations are normal and will last less than a minute. Patients often report a short period where they feel flushing or a warm sensation over the entire body. Complications resulting from this type of IV contrast examination are infrequent and include but are not limited to nausea, hives, vomiting, rash and, rarely, kidney failure or death.

Special Safety Considerations

Inform you physician or imaging technologist of any medications, medical supplements or nonprescription drugs you are taking.

For you safety, inform your physician or imaging technologist if the follow apply.

- You are pregnant or think there is a possibility that you may be pregnant
- You are diabetic and taking *Metformin* or any diabetic medication in combination with *Metformin*. (Provide your technologist a complete list of all oral medications you are taking.)
- You are allergic to any medications or foods, specifically shellfish or shrimp
- You have had an allergic reaction to iodine IV contrast (dye)
- You have multiple myeloma, pheochromocytoma, sickle cell anemia or thyroid disease

Financial Responsibility

Medicare and most health insurances cover this procedure. If for any reason your insurance does not cover nonionic contrast agents, you will be responsible for payment. Payment arrangements are available.

Patient Signature

I, the undersigned, to the best of my knowledge have answered the questions listed on the medical history form accurately and truthfully. I have been informed of the possible complication of this procedure and voluntarily consent to this examination. I hereby authorize Urology San Antonio to release my imaging/X-rays and corresponding reports for the purpose of comparison and follow-up care. I further acknowledge financial responsibility for these services not covered by my insurance.

Patient or Patient's Guardian Signature

Date

Patient or Patient's Guardian Printed Name

Urology San Antonio Witness Printed Name

Date