Bertrand Chaffee Hospital
224 East Main Street
Springville, NY 14141
716-592-8169

Department of Radiology **Consent for Contrast Injection**

Date _____

Your doctor has ordered an xray or CT scan that requires the injection of contrast medium ("dye"). This material improves visualization of blood vessels, organs, lymph nodes, tumors, and infections.

You will receive 50 to 120 milliliters of Isovue by needle or IV. Within minutes, your body removes this material from the bloodstream and concentrates it in the urine.

Isovue may cause a feeling of warmth or a bad taste in the mouth. Rarely, patients experience more serious reactions including hives, nausea, or vomiting. It is reported that one person in 10,000 experiences a life-threatening reaction such as airway swelling or shock. Serious reactions will usually occur within a few minutes of injection; you will be treated here, should a reaction occur.

Contrast may cause damage to the kidneys. If you have medical kidney disease (not kidney stones), are diabetic, or take metformin, you may require a kidney function blood test before contrast is injected.

There is risk associated with many medical procedures. Your doctor feels that the important information acquired from your contrast enhanced xray or CT is worth the tiny risk of a serious reaction.

IVP PATIENTS - Please fill out the questionnaire below so that we may assess your risk for contrast reactions.
CT PATIENTS – Skip to "ALL PATIENTS" and fill out the other side of this form.

What are you allergic to? _____

Are you diabetic? _____

Do you take metformin, Glucophage, or Glucovance? _____

Do you have kidney disease (other than stones)? _____

Do you have multiple myeloma or sickle cell anemia? _____

Do you have asthma? _____

Do you have congestive heart failure? _____

Have you had a reaction to contrast before? _____

ALL PATIENTS – Please sign consent.

I have read this paper and have had a chance to ask questions about the contrast injection. I consent to the intravenous administration of Isovue.

Patient signature _____

Patient guardian or parent _____

Witness _____

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CT CONTRAST SURVEY

NAME..... DATE.....

DATE OF BIRTH..... CT ORDERED .....

ORDERING MD.....

1. Are you allergic to anything?..... Yes .....No.....

   If so, what? .....

2. Have you ever had IV contrast ("dye") before? ..... Yes .....No.....

   Have you had a reaction to the contrast? ..... Yes .....No.....

3. Do you have heart failure? ..... Yes .....No.....

   Other heart disease?..... Yes .....No.....

   Diabetes? ..... Yes .....No..... Glucophage/metformin? .....

   Lung disease?..... Yes .....No.....

   Kidney disease?..... Yes .....No.....

   Cancer?..... Yes .....No.....

   Multiple myeloma (a type of bone cancer) ..... Yes .....No.....

   Sickle cell anemia? ..... Yes .....No.....

   Other medical problems?..... Yes .....No.....

4. What surgery have you had? .....

   .....

5. Please list your medications:.....

   .....

6. When did you last eat or drink anything? .....

   Have you recently had a barium study, such as upper GI or enema? .....

   Female patients: any chance of pregnancy? ..... Date of last period .....

NURSING ONLY----------

PO contrast..... Isovue 300 ..... mls

Injection site..... Flow rate.....

Reaction .....

Nurse signature .....