CONTRAST CONSENT and INFORMATION FORM

Your doctor has requested that you have a CT scan or x-ray examination, which may require the injection of a contrast medium (x-ray dye). When contrast is used, it is injected directly into a vein and may cause a mild warm sensation (hot flush) that can last for up to two minutes.

It is important that you understand the small risks and possible implications that can be associated with this medical procedure. Occasionally, mild allergic reactions such as rash, sneezing and/or hives may occur. Less commonly, nausea, chills, sweating and vomiting may occur. Usually these symptoms will occur at the time of the procedure but occasionally they may occur later as a delayed reaction, most often in the first 30 minutes after injection. Very rarely more severe reactions may occur, including asthma, shock and circulatory disturbances, which may require intensive treatment. In approximately 1:180,000 injections of non-ionic contrast, there is a critical outcome.

Overall, it is considered an extremely safe procedure. Your doctor has considered this diagnostic test to be important in your management.

Please tick your response

Have you ever suffered with Asthma? ☐ **No** ☐ **Yes**
If yes; what asthma medications are you taking? _____
If yes; have you ever been admitted to hospital for your Asthma? ☐ **No** ☐ **Yes**

Do you have any Allergies? ☐ **No** ☐ **Yes**
If yes; list these and your reaction _____

Have you ever had an x-ray examination involving an injection of x-ray dye? ☐ **No** ☐ **Yes**

Have you ever had a reaction to x-ray dye? ☐ **No** ☐ **Yes**
If yes; what was your reaction? _____

Are you being treated for heart or kidney disease? ☐ **No** ☐ **Yes**
If yes, what condition(s) are you being treated for? _____

Are you diabetic? ☐ **No** ☐ **Yes**
If yes; what medications are you taking? _____

Have you had previous surgery with relevance to this examination? ☐ **No** ☐ **Yes**
If yes; please list _____

Please list any serious diseases you have or think that the Radiologist should know about
eg; Myeloma, Sickle Cell Anaemia, Infectious Diseases _____

Are you taking any medications? ☐ **No** ☐ **Yes**
If yes; please list _____

Are you on any blood thinners eg. Warfarin or Aspirin? ☐ **No** ☐ **Yes**
If yes; what are you taking? _____
If yes; what is your latest INR _____ Date: _____

What are your current symptoms?

Are you breast-feeding? ☐ **No** ☐ **Yes**
Is there any chance you could be pregnant? ☐ **No** ☐ **Yes**

Please feel free to ask the Doctor or Radiographer for any further information you require before proceeding with your x-ray examination.

I understand the risks involved and have been given the opportunity to ask questions about the use of contrast. **I consent to contrast (dye) administration.**

Name (please print) _____ Signature _____ Date _____