Contrast CT / MRI Consent

Informed consent. The radiologist fills the treatment details and explains them; the patient or their representative signs.

Clinic and clinician

HOSPITAL OR CLINIC

RADIOLOGIST NAME

REGISTRATION NO. (MEDICAL COUNCIL)

PATIENT ID / UHID

Patient

PATIENT FULL NAME

EMAIL

DATE OF BIRTH

GENDER

PHONE

Proposed treatment

SCAN

PLANNED DATE

Contrast dye is injected into a vein to make organs and vessels show clearly. You may feel warmth or a metallic taste for a moment.

Risks

Every treatment carries some risk. The common and the serious ones for this treatment include:

- Mild reaction: nausea, itching, rash
- Severe allergic reaction (rare); emergency drugs are on hand
- Kidney strain in people with kidney disease
- Leak of dye under the skin at the injection site

RISKS SPECIFIC TO THIS PATIENT

Alternatives

- A scan without contrast, which may show less
- Ultrasound or another test

Your health

Have you reacted to contrast dye before?

◯ No ◯ Yes

Do you have kidney disease or diabetes on metformin?

○ No ○ Yes

Do you have a pacemaker, cochlear implant or metal in your body (for MRI)?

○ No ○ Yes

Are you pregnant or breastfeeding?

○ No ○ Yes

ALLERGIES, CURRENT MEDICINES, OR DETAILS OF ANY "YES"

SERUM CREATININE / EGFR (IF CHECKED)

CONTRAST AGENT AND DOSE

Consent

EXPLAINED TO ME IN

SIGNED BY

REPRESENTATIVE NAME (IF NOT PATIENT)

RELATIONSHIP

- The radiologist has explained the treatment, its purpose, risks and alternatives in a language I understand, and answered my questions.
- I understand no result can be guaranteed.
- This consent covers only the treatment described. If an unexpected problem arises during it that puts life or health at immediate risk, the team may do what is needed to deal with it and will explain afterwards.
- I may withdraw this consent at any time before the treatment starts.

☐ I give my consent to the treatment described above.

Patient

SIGNATURE

PRINTED NAME

DATE

Radiologist

SIGNATURE

PRINTED NAME

DATE