CHESAPEAKE MEDICAL IMAGING

CONTRAST INJECTION CONSENT FORM FOR CT

Patient Name: _____ **DOB:**_____

Please circle any of the conditions below that currently apply to you:

☐Yes ☐No Asthma
☐Yes ☐No Kidney problems or dialysis
☐Yes ☐No Diabetes
☐Yes ☐No Thyroid Storm (or about to be treated with radioactive iodine for hyperthyroidism)

Please notify the technologist if you are taking the following diabetic medications:
Glucophage, Metformin, Glucovance or Glyburide

☐Yes ☐No Have you had an exam that required IV Contrast (x-ray dye, iodine-based contrast)
☐Yes ☐No If yes, did you have any problems with IV Contrast?

I consent to the use of a contrast agent. I understand that, as with any medications, there is a risk of minor to severe reactions which can potentially lead to cardiac or respiratory arrest. These have been explained to me in a language that I understand and I consent to having the procedure.

_____ _____
PRINT NAME DATE

_____
PATIENT SIGNATURE/ GUARDIAN

_____ _____
TECHNOLOGIST DATE