CAROLINA NeuroSurgery & Spine ASSOCIATES

MRI - Intravenous Contrast Information & Consent Form

Patient name_____ Patient Age _____ MR#_____

Your doctor has recommended that you have an MRI exam which requires contrast (dye). The contrast will be injected into your veins to visualize parts of your body better during the examination. The majority of patients have no complaints or symptoms following the contrast injection.

During the examination, you may experience a cold sensation, headache, nausea, or dizziness. Less frequently, you may experience an allergic type reaction with itching and possibly hives (raised skin resembling mosquito bites). Other symptoms such as localized swelling of the eyes and lips, sneezing, difficulty breathing, or hypotension (low blood pressure) can occur. ******If you experience any of the above symptoms within 24 hours, please notify your referring physician or go to the emergency room**.

In rare instances, more serious complications can be encountered. While it would be impractical or mis-leading to describe them all, these complications include shock, kidney failure, and/or cardiac arrest. We have emergency personnel on-site to treat these reactions immediately, if needed; however, despite vigorous emergency treatment, it is always possible, although highly unlikely, that a fatality could occur. Your doctor has determined that the diagnostic information outweighs the minimal risk of the procedure.

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Please circle if you have a history of the following:

☐ **Asthma** ☐ **Seizures** ☐ **Sickle Cell Anemia** ☐ **Severe Liver Disease/transplant/pending transplant**
☐ **Diabetes** ☐ **Kidney Removed/Transplant** ☐ **Multiple Myeloma** ☐ **Hypertension that requires medication**

☐ **YES** ☐ **NO** **Have you had blood work taken in past 45 days (If yes, where?) _____**

☐ **YES** ☐ **NO** **Do you have a history of drug allergy or previous allergy to X-ray/MRI contrast?**

(If yes, please describe):_____

☐ **YES** ☐ **NO** Are you currently taking aminoglycoside antibiotics such as **Tobramycin, Gentamycin** or **Amikacin**

☐ **YES** ☐ **NO** Are you currently taking oral medications for diabetes such as **Glucophage**, **Avandemet**, **Metaglip**, **Glucovance**, **Glumetza**, **Fortamet**, or **Riomet**. (MRI patients do not need to discontinue these medications before or after exam)

******BY SIGNING BELOW, YOU ARE GIVING CONSENT FOR MRI CONTRAST TO BE ADMINISTERED******

Signature: _____ Relationship to patient _____

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(Office use only)

Brand of Contrast: Gadavist Lot#_____ Exp. Date_____

If applicable: Creatinine _____ Estimated GFR_____

Technologist signature _____ Date: _____