CAROLINA
NeuroSurgery & Spine
ASSOCIATES

CT - Intravenous Contrast Information & Consent Form

Patient name_____ Patient Age _____ MR#_____

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

During the examination, you may experience a warm sensation, sometimes nausea, or dizziness. Less frequently, you may experience an allergic 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 after your exam, 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. 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: Lupus Sever Liver Disease/ Transplant

Asthma Pheochromocytoma Sickle Cell Anemia Myesthenia Gravis Heart Disease

Diabetic Renal Failure Kidney Disease Multiple Myeloma Allergic to X-ray contrast

YES / NO Have you had blood work (Creatinine) taken in past 45 Days (If yes, where): _____

_____

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

(If yes, please describe):_____

YES / NO Are you currently taking oral medications for diabetes such as **Glucophage**, **Avandemet**, **Metaglip** , **Glucovance**, **Glumetza**, **Fortamet**, **Riomet**, or **Metformin.**

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

Signature: _____ Relationship to patient_____

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(Office use only)

: Omnipaque-300_ Lot#_____Exp. Date_____Amount cc_____

If applicable: Creatinine_____ BUN_____ Estimated GFR_____

Technologist signature_____