

Carolina Neurosurgery & Spine Associates, PA

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 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 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 misleading 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.

Please circle if you have a history of the following:

- | | | | | |
|---------------------|---------------|------------------|--------------------------|-------------------|
| Asthma | Emphysema | Pheochromocytoma | Sickle Cell Anemia | Myesthenia Gravis |
| Diabetes | Seizures | Kidney Removed | Lupus | Multiple Myeloma |
| Angina (chest pain) | Heart Disease | Heart Attack | Congestive Heart Failure | |

YES / NO Have you had blood work taken in past 3 months (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 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.**

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

Signature: _____ Relationship to patient _____

(Office use only)

Brand of Contrast: Omnipaque _____ Lot# _____ Exp. Date _____

If applicable: Creatinine _____ BUN _____ Estimated GFR _____

Technologist signature _____