



PATIENT DISCLOSURE AND INFORMED CONSENT - CT

Patient Name _____ WEIGHT: _____ MR# _____

Your doctor has requested that you have a Computed Tomography (CT) examination to aid in your medical diagnosis. CT is a medical imaging procedure, which utilizes x-rays and sophisticated electronic equipment to visualize the internal body structures.

PLEASE READ AND CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS:

| | | | | | |
|---|-------|----|-----------------------------|-----|-------|
| Are you wearing a wig or hairpiece? | Yes | No | Heart disease? | Yes | No |
| Are you wearing dentures or partial? | Yes | No | Congestive heart failure? | Yes | No |
| Are you wearing a hearing aid? | Yes | No | Irregular heart beat? | Yes | No |
| Are you wearing an ostomy appliance? | Yes | No | High blood pressure? | Yes | No |
| Are you wearing an artificial eye or limb? | Yes | No | Cancer? | Yes | No |
| Are you wearing a neurostimulator? | Yes | No | If Yes, radiation therapy? | Yes | No |
| Have you ever had any surgeries? | Yes | No | If Yes, chemotherapy? | Yes | No |
| If Yes, when & what? | | | Diabetes? | Yes | No |
| _____ | | | If Yes, taking Glucophage? | Yes | No |
| _____ | | | Kidney disease? | Yes | No |
| _____ | | | Kidney failure? | Yes | No |
| Date of last menstrual period | _____ | / | _____ | / | _____ |
| Is there any possibility you are pregnant? | Yes | No | Lung disease? | Yes | No |
| Are you nursing an infant? | Yes | No | Asthma or Emphysema? | Yes | No |
| Allergies? | Yes | No | Sickle cell anemia? | Yes | No |
| Have you ever had a reaction to contrast injection? | Yes | No | Multiple Myeloma? | Yes | No |
| Do you have seizures? | Yes | No | Any other medical problems? | Yes | No |
| Severe dehydration? | Yes | No | If Yes, describe below: | | |
| | | | _____ | | |

I understand that the procedure to be performed on me involves the use of x-rays, and possibly injection needles and iodine containing solutions (x-ray dye), which may enhance the diagnostic accuracy of the procedure.

You may be receiving an intravenous contrast media and/or oral contrast media to enhance the visibility of certain tissues. Possible side effects may include, but are not limited to, pain or swelling at the site of injection, nausea, vomiting, a warm flushed feeling, potential allergic reaction including, but not limited to hives, wheezing, difficulty breathing, and in rare instances, anaphylactic shock (severe allergic reaction). More severe reactions may occur, including death, but these are very rare and the value of the diagnostic information, which may be obtained, outweighs the risk of the procedure. The purpose, benefits and complications of the contrast procedure will be explained to your satisfaction before any injection takes place. A basic kidney function test will be performed if you have a history of kidney disease, kidney failure, or have other risk factors, according to standard medical practice.

I hereby consent to any measure necessary to correct complications which may occur. I am aware that the practice of medicine is not exact science and I acknowledge that no guarantees have been made to me concerning the results of this examination.

I confirm that the information I provided is complete and accurate to the best of my knowledge.

I have read, understand, and hereby consent to this CT examination.

Patient Signature / Parent or Guardian if Patient is a Minor

Date

Witness Signature

Date