Orange County Diagnostics
Offices: Mission Viejo, Ladera Ranch and Laguna Woods

Office Use Only

MRN __________

CONSENT and SCREENINGfor ADMINSTRATION OF
RADIOGRAPHIC CONTRAST MATERIAL

Name: ____ DOB: __ /__ /_____

Do you have any of the following (please circle)?

□ Yes □ No Age > 70

□ Yes □ No Previous reaction to X-Ray contrast

□ Yes □ No Allergies to Iodine

□ Yes □ No Asthma

□ Yes □ No Kidney Failure (personal or family history)

□ Yes □ No Single kidney, nephrectomy, and/or kidney transplant

□ Yes □ No Heart Trouble (including but not limited to congestive heart failure)

□ Yes □ No Insulin or non-insulin dependent diabetes

□ Yes □ No Collagen Vascular Disease (RA/SLE/Scleroderma/ other vasculitis)

□ Yes □ No General Debility (eg. AIDS, Advance tumor)

□ Yes □ No Currently taking medication that is potentially toxic to the kidney

□ Yes □ No Are you currently on dialysis

□ Yes □ No Do you take Glucophage (Metformin), Glucovance, or Avandamet for Diabetes?

Your physician has requested a CT or x-ray examination that involves an injection of iodinated contrast into one of your veins. The contrast circulates through your blood vessels and highlights the x-ray images of your body. Most patients experience no unusual effects from this injection. As with any procedure, some risk may be involved. During the injection, the patient may experience a warm sensation, nausea or vomiting. A few patients have an allergic-type reaction which may include itching and hives (raised skin reactions resembling mosquito bites), swelling of the eyes or lips, sneezing, or (rarely) difficulty breathing.
Medications are on hand to treat these conditions should they occur. In rare instances, more serious complications may occur. These complications include, but are not limited to skin damage, shock, kidney failure and cardiac arrest. We have facilities to treat these reactions immediately. However, despite emergency treatment, some fatalities do occur (1 in 10,000 to 350,000 procedures). Your healthcare provider and the Radiologist are aware of these possible complications, but have determined that the diagnostic information the iodinated contrast provides outweighs the minimal risk of the procedure.

I have read the above and understand the information provided. I give my consent to have this examination performed with iodinated contrast.

Signature of patient/parent/guardian: ______________________________ Date: __ /__ /_____

Relationship to patient: ____