

IF YOU ARE PREGNANT, PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY

Are you or could you be pregnant? YES NO _____ (Initial) Date of last menstrual cycle ____/____/____

Are you currently breast feeding? YES NO _____ (Initial)

Have you had anything to eat in the last 3 hours? YES NO If YES, what time? _____

What symptoms or complaints brought you here? _____

Please specify the location and duration of symptoms: _____

Which side? RIGHT LEFT OTHER _____

HAVE YOU EVER HAD A SEVERE, LIFE THREATENING OR ANAPHYLACTIC REACTION TO FOOD, MEDICATION, INSECT OR BUG BITES? YES NO IF YES, PLEASE EXPLAIN _____

Do you have any allergies? YES NO If YES, Explain _____

HAVE YOU HAD A CONTRAST DYE INJECTION BEFORE? YES NO
If YES, did you have any problems or reactions to this injection? YES NO
If YES, please explain _____

Have you been medicated for this procedure? YES NO Tech Initials _____

PLEASE LIST ALL PRIOR SURGERIES: None _____ Date ____/____/____
 _____ Date ____/____/____
 _____ Date ____/____/____

Have you ever been diagnosed with cancer or serious illness? YES NO
If YES, Have you had chemotherapy? YES NO Dates: ____/____/____
If YES, Have you had radiation therapy? YES NO Dates: ____/____/____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?
Do you have Asthma? YES NO If YES, are you currently symptomatic? YES NO
High Blood Pressure? YES NO Lung Disease? YES NO
Shortness of Breath? YES NO Heart Disease? YES NO
Kidney Dysfunction? YES NO
Are you currently on Dialysis? YES NO If YES, date of next session ____/____/____

Are you or have you ever been a smoker? YES NO Are you a diabetic? YES NO If YES, are you taking:
If YES, How many packs per day? _____ Glucophage Metformin or Glucovance
For how many years? _____ (please circle and initial)

I attest that the information provided on this form is true to the best of my knowledge.

Signature of Patient or Guardian or Person Authorized to Consent for Patient Date

Technologist Notes:

Tech Signature

I, _____, the patient named below, the parent of the minor patient named below or the legal guardian of the patient named below, authorize the performance upon the patient of the following diagnostic procedure(s):

Computerized Tomography (CT)

The patient's physician has requested that Pinnacle Hospital perform a Computerized Tomography examination to obtain additional information. A CT examination is an imaging method that involves the use of X-ray radiation and computers to produce medically useful images of the body part of concern.

Magnetic Resonance Imaging (MRI)

The patient's physician has requested that Pinnacle Hospital perform a Magnetic Resonance Imaging examination to obtain additional information. A MRI examination is an imaging method that uses magnetism, radio waves and computers to produce medically useful images of the body part of concern.

I understand that I have the right to be informed about my condition and the recommended diagnostic procedure to be used in order that I may make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved.

If the patient is pregnant, thinks she may be pregnant, is breastfeeding, I will inform Pinnacle Hospital personnel at once.

To properly study the area of concern during your CT or MRI examination, it is sometime necessary to intro an IV contrast agent into the body. Contrast agents enhance the visibility of certain tissues in the body and further assist in making a correct diagnosis. All the contrast agents used in our facility have been approved by the Food and Drug Administration and are considered safe.

Potential Risks: Anytime an injection is given, there is potential for pain, bleeding, bruising, swelling or infection at the injection site. Additional allergic reactions in response to the contrast agents may include hives, shortness of breath or difficulty swallowing. There have been rare instances of kidney failure, kidney damage or death after the administration of the contrast agent. *It is very important that you inform the technologist if the patient experiences any or has previously had a reaction to a contrast agent.*

An alternative to the procedures listed above may be an ultrasound, x-ray, nuclear medicine examination or no treatment.

I understand that the patient's physician has requested the CT or MRI to aid in the medical diagnosis and that the patient will benefit from this procedure, as this diagnostic test may offer information not available from other techniques.

I have read, understand and hereby consent to a CT / MRI (circle one) examination and the above conditions.

Patient (Please Print)	
Parent/ Legal Guardian Name (Please Print)	
Patient/Parent/Legal Guardian Signature	
Relationship if not Patient	
Date and Time	<input type="checkbox"/> A.M. <input type="checkbox"/> P.M.
Witness Signature	



Consent for CT/MRI with IV Contrast Injection