



**INFORMED CONSENT FOR "CT" SCAN WITH CONTRAST MATERIAL**  
**DO NOT SIGN THIS FORM UNTIL YOU HAVE READ AND FULLY UNDERSTAND ITS CONTENTS**

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

The following has been explained to me in general terms and I understand that:

1. The contrast material is given through a small needle placed into a vein, usually on the inside of your elbow or on the back of your hand. Normally, contrast material is considered quite safe: however, any injection carries slight risks of harm including injury to nerve, artery, or vein, infection, or reaction to the material being injected. Occasionally, a patient will have a mild reaction to the contrast agent and develop sneezing or hives. Uncommonly (one case in a thousand), a serious reaction to the contrast occurs. The physicians and staff of the x-ray department are trained to treat these reactions. Very rarely (1:40,000), death has occurred related to contrast administration; the risk of such a severe consequence is similar to that from the administration of penicillin.

Certain patients are at higher risk for experiencing a reaction to the contrast agent. Patients who are higher risk for adverse effects of contrast are:

1. People who have already had a moderate or severe "allergic like" reaction to contrast material which required treatment;
2. People with severe allergies or asthma;
3. Patients with severe or incapacitation heart disease;
4. Patients with multiple myeloma, sickle cell disease, polycythemia, or pheochromocytoma;
5. Patients with severe kidney disease, particularly caused by diabetes.

**2. MATERIAL RISK OF THIS PROCEDURE:**

As a result of this procedure being performed, there may be material risks of: INFECTION, ALLERGIC REACTION, DISFIGURING SCAR, SEVERE LOSS OF BLOOD, LOSS OR LOSS FUNCTION OF ANY LIMB OR ORGAN, PARALYSIS, PARAPLEGIA OR QUADRIPLEGIA, BRAIN DAMAGE CARDIAC ARREST OR DEATH.

3. In addition to these material risks, there may be other possible risks involved in this procedure including but not limited to: Allergic rash, swelling of the lips or eyelids, and difficulty breathing.

4. I understand that the physician, medical personnel and other assistants will rely on statements about the patient, the patient's medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which has been explained. I understand that the practice of medicine is not an exact science and that NO GUARANTEES OR ASSURANCES HAVE BEEN MADE TO ME concerning the results of this procedure.

**BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE READ OR HAD THIS FORM READ AND/OR EXPLAINED TO ME; THAT I FULLY UNDERSTAND ITS CONTENTS, AND THAT I HAVE BEEN GIVEN AMPLE OPPORTUNITY TO ASK QUESTIONS AND THAT ALL QUESTIONS HAVE BEEN ANSWERED SATISFACTORILY. ALL BLANKS OR STATEMENTS REQUIRING COMPLETION WERE FILLED IN AND ALL STATEMENTS I DO NOT APPROVE OF WERE STRICKEN BEFORE I SIGNED THIS FORM. I ALSO HAVE RECEIVED ADDITIONAL INFORMATION INCLUDING BUT NOT LIMITED TO THE MATERIALS LISTED BELOW RELATING TO THE PROCEDURES DESCRIBED HEREIN.**

I voluntarily consent to Dr. Lee or any other physicians designated or selected by him/her and all medical personnel under the direct supervision and control of such physicians and all other personnel who may otherwise be involved in performing such procedures to perform the procedures described or otherwise referred to herein.

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Person giving consent

Relationship to patient if not the patient \_\_\_\_\_

Patient unable to sign because \_\_\_\_\_