

## INTRAVENOUS PYELOGRAM INFORMED CONSENT

*(For Privacy Act information, see DD Form 2005.)*

Dear Patient:

Your doctor has referred you for an intravenous pyelogram (IVP). This is a specialized x-ray study of the kidneys, ureters and bladder. During this study an iodinated radiographic contrast will be injected into one of your blood vessels. This is done so your kidneys will be visible in the x-ray. Typically, the injection is into your arm.

The majority of patients tolerate the injection well and experience no unusual side effects. It is not uncommon for patients to experience a warm flushing sensation, a metallic taste or nausea during the injection. In rare instances, allergic reactions to the injection may occur. The vast majority of these are mild and typically consist of itching, hives, redness or mild shortness of breath. In rare instances, severe, life-threatening and sometimes fatal reactions may occur. Statistically, these occur in one patient per 30,000 to 40,000. Your doctor is aware of these possible complications but is of the opinion that the diagnostic information which your IVP provides outweighs the above noted risks.

If you have any questions about the procedure, our staff will be happy to answer them, either before or at the time of the study.

I have read and understand the above statement:

Patient's signature: \_\_\_\_\_ Date: \_\_\_\_\_

### SECTION I - QUESTIONNAIRE FOR INTRAVENOUS PYELOGRAM

1. Patient's name <i>(Last, First, Middle)</i>	2. Sponsors social security number	3. Home phone number
4. Home address <i>(Street and number, city or installation, state, Zip code)</i>		5. Duty phone number
6. Do you have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	7. If you answered "Yes" to question 6, what are you allergic to?	

8. Do you have a history of any of the following?

Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lung disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney failure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Multiple myeloma	<input type="checkbox"/> Yes	<input type="checkbox"/> No

### SECTION II - AUTHENTICATION

9a. Patient's signature		9b. Date
10a. Witness' printed name	10b. Witness' signature	10c. Date
11a. Radiologist's printed name or stamp	11b. Radiologist's signature	11c. Date

### SECTION III - FOR RADIOLOGY USE ONLY

BUN/CR:

Contrast type/volume:

Radiologist: