

COMPUTED TOMOGRAPHY INFORMED CONSENT

Your doctor has referred you for a computed tomographic (CT) scan. This is a specialized x-ray study in which detailed images of the body are generated by a computer. During this study, an iodinated radiographic contrast will be injected into one of your blood vessels. This is done to enhance the images, producing more detail for interpretation. 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 CT scan will provide outweighs the above noted risks.

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

QUESTIONNAIRE - TO BE COMPLETED BY PATIENT

1. Name (<i>Last, First, Middle</i>)	2. Sponsor's social security number	3. Home phone
4. Address (<i>Street, City or Installation, Zip code</i>)		5. Duty phone
6a. Do you have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	6b. If you answered "Yes" to question 6a, what are you allergic to?	
7. 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		
8a. Have you had any previous surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No	8b. If you answered "Yes" to question 8a, what type?	
9a. Are you taking any medications now? <input type="checkbox"/> Yes <input type="checkbox"/> No	9b. If you answered "Yes" to question 9a, please list them.	
10a. Are you a diabetic? <input type="checkbox"/> Yes <input type="checkbox"/> No	10b. If you answered "Yes" to question 10a, do you take glucophage (Metformin)? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Patient's name	Patient's signature	Date
Witness' name	Witness' signature	Date
Radiologist's name	Radiologist's signature	Date

FOR RADIOLOGY USE ONLY

BUN/CR:

CONTRAST TYPE/VOLUME:

SCAN PROTOCOL: