

CONSENT FOR CONTRAST MATERIAL ADMINISTRATION

Your physician has scheduled you for an x-ray examination that require an injection of a contrast agent into your bloodstream and/or ingestion of oral contrast for opacification of your bowel. These contrast agents help the Radiologist interpret the films.

PROCEDURE: Computerized Tomography (C.T.) Intravenous Pyelography (IVP)
 Other _____

The contrast material is injected 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 a slight risk of harm including infection, injury to a nerve, artery, vein, or reaction to the material being injected. Occasionally, a patient will have a mild reaction to the contrast material and develop sneezing or hives. The incidence a serious reaction (such as anaphylactic shock or impaired renal function), is only about 4 out of every 10,000 exams performed. In extremely rare cases, death has occurred. (Reports vary from 1 in 10,000 to 1 in 140,000 exams.)

Certain patients are at higher risk for experiencing a reaction to the contrast agent. In order to help us determine your risk factor please answer the following questions:

Patient History:

1. Allergy to medications (specify - Sulfa, Penicillin, etc.)
2. Allergy to contrast dye
3. Have you had x-ray contrast within the last 7 days.

	Y	N	ICD- 9 Codes If yes, Please Specify
_____	_____	_____	V 14.0 - V 14.9
_____	_____	_____	V 15.0
_____	_____	_____	

Respiratory:

1. Asthma
2. Ventilator/Respirator dependent
3. Pulmonary-Heart Disease

_____	_____	_____	493.90-493.91
_____	_____	_____	V461
_____	_____	_____	416.9

Heart Disease:

1. Heart Attack within the last 8 weeks
2. Unstable Angina
3. Congestive Heart Failure
4. Atherosclerosis (Hardening of arteries)
5. Cardiac Arrhythmia (Irregular heart beat)
6. Hypertensive Heart Disease with or without heart failure
7. Myocarditis
8. Other unspecified heart disease (cardiomegaly, etc.)
9. Tachycardia
10. Recent major surgery a (CABG, etc...)

_____	_____	_____	410.92
_____	_____	_____	411.1
_____	_____	_____	428.0
_____	_____	_____	429.2
_____	_____	_____	427.0-427.9
_____	_____	_____	402.90-402.91
_____	_____	_____	429.0
_____	_____	_____	429.9
_____	_____	_____	785.00

Blood Disorder:

1. Thalassernia (anemias)
2. Sickle cell anemia/disease

_____	_____	_____	282.4
_____	_____	_____	282.60-282.69

Other:

1. Diabetes Mellitus
2. Renal Failure / Recent renal surgery
3. Multiple Myeloma
4. Debility, unspecified (weakness of tonicity in functions or organs of the body)

_____	_____	_____	250.0-250.93
_____	_____	_____	585-586
_____	_____	_____	203.00-203.01
_____	_____	_____	799.3

Do you have high blood pressure Yes No
 Do you take Glucophage / Metformin (Antihyperglycemic medicine)? Yes No _____

After the determination of your risk factor, we will ask for your signature below. If you have any questions, please ask the technologist and physician at this time, before signing.

I have read the above information and understand that there are risks involved. I have had my questions answered and give my consent for this exam.

Patient Signature: _____
 Patient Name: (please print) _____
 Date: _____ Time: _____ Witness: _____ Date: _____ Time: _____
 Patient weight: _____ Age: _____ Serum Creatine: _____ BUN: _____ Creatine Clearance: _____
 IV Contrast: _____ # of ml's injected: _____ Time of injection: _____ Injected by: _____
 Oral Contrast: _____ # of ml's ingested: _____ Time given: _____ Administered by: _____



500 West Main
Lewisville, Texas 75057-3699

PATIENT IDENTIFICATION

**DEPARTMENT OF RADIOLOGY CONSENT FOR
CONTRAST MATERIAL ADMINISTRATION**



Imaging Services Home Medication Evaluation Form

List all Medication or Contrast along with Strength and Dose to be given in Imaging:

Ordering MD:

Test Ordered:

Diagnosis:

Technologist:

Allergies:

Lab Values:

Radiologist:

Safety Precautions:

Dear Physicians: To reduce medication errors and promote patient safety, any issues between home medications and treatment medications need to be addressed. To assist you, the staff will be completing this form which lists the medications the patient (or family member) states are being taken at home. Please review PRIOR to administration of any preparatory or procedural medications and make the appropriate recommendation as to whether to proceed. Upon discharge, the patient will be given a copy for their next provider of care. Once again, please review the list and ensure that you have evaluated all home medications as appropriate. Thank you very much for your assistance.

Information From:

- Medication List Provided by Patient/Other _____ Actual medications/bottles brought in.
 Verbal report from Patient/Other _____ Nursing Home list/MAR
 Patient/Other denies any home medications to include OTC, vitamins, herbal medications & supplements

Home Medication

Reconciliation

(Prescriptions, Over the Counter, Herbals, Eye Drops, Supplements)

Item Name, Dose, Route, Frequency (Use an additional sheet if necessary)	Date/Time Last Dose Taken

Note to ordering physician:

Parenteral *radiographic contrast administration* may cause acute renal failure and has been associated with lactic acidosis in patients on metformin. Patients undergoing studies using iodinated radiographic contrast media should have **metformin** or drug combinations containing **metformin** (**Glucophage, Glucophage XR, Glucovance, Riomet, Fortamet, Metaglip, Actoplus met, Avandamet**) temporarily withheld just prior to and 48 hours after the completion of the procedure.

Reinstitute therapy only after normal renal function has been confirmed

On Admission:

Date/Time & Signature of Healthcare Provider completing Form

Reconciliation performed, may proceed with TEST:

Date/Time & Physician or Pharmacist Signature

DO NOT PROCEED with test at this time, will discuss with Primary Care Physician.

Date/Time & Physician or Pharmacist Signature

On Discharge:

Follow up with your Primary Care Physician regarding your home medications.

*****Be sure to take this Medication List with you to your next doctor visit*****

* Call Pharmacy at ext. 1043 for any questions - This document is part of the permanent medical record*
Place form in Physician's Order section of the chart.



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**HOME MEDICATION EVALUATION
FORM**



POS

Form P0728-006 (Rev. 04/06)

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