CAROLINA NeuroSurgery & Spine ASSOCIATES

CT - INTRAVENOUS CONTRAST INFORMATION & CONSENT FORM

Patient name: _____ MR# _____

Your doctor has recommended that you have a CT exam, which requires contrast (dye). The contrast will be injected into your veins to better visualize parts of your body. The majority of patients have no complaints or symptoms following the contrast injection.

During the examination, you may experience a warm sensation, sometimes nausea, or dizziness. Less frequently, you may experience an allergic reaction with itching and possibly hives (raised skin resembling mosquito bites). Other symptoms such as localized swelling of the eyes and lips, sneezing, difficulty breathing, or hypotension (low blood pressure) can occur.

******If you experience any of the above symptoms within 24 hours, please notify your referring physician or go to the emergency room. ******

In rare instances, more serious complications can be encountered. While it would be impractical or misleading to describe them all, these complications include shock, kidney failure, and/or cardiac arrest. We have emergency personnel on-site to treat these reactions immediately. However, despite vigorous emergency treatment, it is always possible, although highly unlikely, that a fatality could occur. Your doctor has determined that the diagnostic information outweighs the minimal risk of the procedure.

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Please circle if you have a history of the following:

Asthma Emphysema Phoechromocytoma Sickle Cell Anemia Myesthenia Gravis

Diabetes Seizures Kidney Removed/Kidney Disease Lupus Multiple Myeloma

Angina (chest pain) Heart Disease Heart Attack Congestive Heart Failure

YES	NO	
		Have you had blood work (Creatinine) taken in past 45 Days? (If yes, where): _____
		Do you have a history of drug allergy or previous allergy to X-ray contrast? (If yes, please describe): _____
		Are you currently taking aminoglycoside antibiotics such as **Tobramycin, Gentamycin,** or **Amikacin**
		Are you currently taking oral medications for diabetes? _____ **For example: Glucophage, Avandemet, Metaglip, Glucovance, Glumetza, Fortamet or Riomet.**

BY SIGNING BELOW, YOU GIVE CONSENT FOR CT CONTR AST TO BE ADMINISTERED

Signature: _____Relationship to Patient: _____ Date: _____

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(Office use only)
Brand of Contrast:
Omnipaque Lot# _____ Exp. Date _____ Amount cc _____

If applicable:
Creatinine _____ BUN _____ Estimated GFR _____

Technologist signature: _____ Date: _____