



**CONSENT FOR CONTRAST AGENT INJECTION**

**Patient Name** \_\_\_\_\_

You have been scheduled for an exam, (CT scan or X-ray), that requires injection of a contrast agent into your bloodstream. Contrast materials are considered safe and effective. Most adverse effects to this type of contrast are mild and may consist of itching, hives, sneezing, nasal stuffiness and/or mild nausea or vomiting. Uncommonly (1 case in 1,000), a serious reaction to the agent occurs.

All forms of IV contrast carry some risk of kidney impairment. Fortunately, this is very low or nonexistent for people with normal kidney function. The Oregon Clinic only uses only non-ionic contrast. Research has shown that non-ionic contrast material is safer than regular IV contrast with respect to kidney function. Risk for kidney injury is greatest for those with pre-existing renal failure and diabetes. As a precaution, all patients are screened and adequate intake of fluid is urged for 12 hours following the exam.

**TO ASSESS YOUR RISK FOR REACTION, PLEASE ANSWER THE FOLLOWING:**

- YES NO**      **Are you allergic to iodine?**  
**If yes, what happened** \_\_\_\_\_
- YES NO**      **Allergies?? Please List** \_\_\_\_\_
- YES NO**      **Asthma??** \_\_\_\_\_
- YES NO**      **Angina, congestive heart failure, or other heart condition**  
**inhibits your activity?**
- YES NO**      **I have kidney disease, kidney failure, or have had a**  
**transplant, or other kidney surgery.**
- YES NO**      **Diabetes?**
- YES NO**      **Are you on INSULIN? If YES, when did you last check your**  
**Blood sugar? \_\_\_\_\_ What was the result? \_\_\_\_\_**
- YES NO**      **I take medication containing Metformin (Glucophage):**  
**Metaglip, Glucovance, Actoplus Met, Avandamet, Foramet,**  
**or Riomet. If uncertain, please speak to the technologist prior**  
**to your exam.**

**\*\* Discontinue Metformin or Glucophage medications for at least 48 hours after the procedure is completed.** \_\_\_\_\_ (Technologist Initials)

**If you are pregnant or think you might be, please LET US KNOW IMMEDIATELY.**

**I have read and understand the above information. My questions have been answered by The Oregon Clinic staff, and I CONSENT TO THE USE OF CONTRAST FOR MY EXAM.**

**Date** \_\_\_\_\_      **Patient Signature** \_\_\_\_\_

\_\_\_\_\_ (Parent/Guardian (if patient under 15 or unable to sign)

**Tech Initials:** \_\_\_\_\_