

CONSENT FOR INTRAVENOUS MRI INJECTION

MEDICAL HISTORY

Do you suffer from:

Heart disease / Cardiac condition	Y___	N___	Allergic / Respiratory disease	Y___	N___
Asthma	Y___	N___	Lactation	Y___	N___
Renal disease	Y___	N___	Allergies to medication?	Y___	N___
Seizure disorder	Y___	N___	If so, please list:		
Anemia/Blood disorder	Y___	N___			

Are you taking any prescribed medications at this time? Y___ N___

If so, list the medication:

Your physician has requested that you have a MRI examination WITH CONTRAST. This will necessitate an intravenous injection of a paramagnetic enhancement contrast medium. The injection will be given into a vein, either in the hand or in the region of the elbow. It is important to realize that without injection, abnormalities may be very difficult or impossible to detect. There are NO known contraindications to the use of this material, however a small percentage of patients will experience a mild reaction in the form of nausea, vomiting and may experience the development of a transient headache. Other adverse reactions have been reported in less than 1% of the patients include: coldness, warmth, hypotension, agitation, dizziness, rash, sweating, ringing in the ears and dry mouth. These reactions are uncommon, transient and are self-limited. Should you experience any of these reactions, we shall treat them with the appropriate medical care using all good and acceptable medical judgment and procedures. There have been no reports of death as a result of this injection. There is no alternate paramagnetic enhancement contrast media.

I acknowledge that I have read this document in its entirety, that I fully understand it, that all my questions have been answered to my satisfaction and that I agree and consent to the use of this diagnostic material.

Signed: _____

Date: _____

Printed Name: _____

Date & time of injection _____ Injection site: _____

Type any amount of contrast injected: _____ Lot#: _____

Signature of person injecting: _____

Comments: _____