Teton Radiology *advanced medical imaging*
2001 S. Woodruff, Suite 17, Idaho Falls, ID 83404 • tel (208) 524-7237 425 E. 4th N., Rexburg, ID 83440 • tel (208) 356-4888

Consent for Special Procedure

Patient		
MRN	Date	Time ☐ AM ☐ PM

My doctor _____ has referred me to an X-ray procedure known as a(n) _____ which may include the use of medications, needles, catheters (tubes), and contrast material to aid in the diagnosis or treatment for my present condition.

I have been informed that there are possible, but infrequent, complications from this procedure(s); such as allergic reactions and damage to the blood vessels or parts next to them, such as nerves. Sometimes medical or surgical treatment may be required to correct these conditions. Rarely, serious complications happen and very rarely death does occur. This procedure(s), however, has been used many times to provide valuable information which far outweighs the potential risks involved.

I do hereby consent to the performance upon me of the procedure(s) indicated above and to the administration of medications, including anesthetics, as may be judged advisable by the physician doing the procedure(s). I also consent to the procedure(s) taken medically or surgically, to attempt to correct any complications which may occur and I assume the risks in connection with the said procedure(s).

I have had sufficient time to review this form and to ask and have answered any and all questions that I felt necessary prior to signing this consent form.

Breast feeding mothers: If you are given an intravenous injection, there is a very small percentage of iodinated contrasted material that is excreted into the breast milk and absorbed by the infant. Available data suggest it is safe to continue breast-feeding. However if you are concerned, you may abstain from breast feeding for 12 to 24 hours (express and discard breast milk).

Signatures

Patient/Guardian signature		Date
If guardian, print name		Relationship to patient
Witness signature	Witness name (please print)	Date

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General Information			
Patient		Age	MRN
Height	Weight	BUN	Creatinine
Diagnosis			
Test ordered		Referring physician	
Reason for test			
Patient History			
Kidney problems ☐ Yes ☐ No	Kidney stone(s) ☐ Yes ☐ No	I.V.P. without reaction ☐ Yes ☐ No	
Surgery ☐ Yes ☐ No	If yes, type of surgery		If yes, date of surgery
Patient Symptoms			
Pain/Burning on urination ☐ Yes ☐ No	Blood in urine ☐ Yes ☐ No	Kidney stones ☐ Yes ☐ No	Nocturia ☐ Yes ☐ No
Prostate problems ☐ Yes ☐ No	Other (specify)		
Patient Conditions (if known)			
Age under 12 ☐ Yes ☐ No	Age over 45 ☐ Yes ☐ No	Asthma or chronic respiratory disease ☐ Yes ☐ No	
Previous allergic reaction to contrast ☐ Yes ☐ No		If yes, when	If yes, what type
Diabetes ☐ Yes ☐ No	Non-insulin dependent ☐ Yes ☐ No	Insulin dependent ☐ Yes ☐ No	
Currently taking Glucophage as prescribed by physician ☐ Yes ☐ No		Do you have any known heart problems ☐ Yes ☐ No	
Multiple myeloma ☐ Yes ☐ No	Unstable angina ☐ Yes ☐ No	Within six months of an acute MI complicated by hypotension ☐ Yes ☐ No	
Prior allergic reaction to:	Iodine ☐ Yes ☐ No	Chocolate ☐ Yes ☐ No	Seafood/shrimp ☐ Yes ☐ No
	Seasonal allergies ☐ Yes ☐ No	Other (please specify)	
The Above Information Was Obtained From			
Name/Relationship to Patient			Hospital Chart ☐

If **none** of the above conditions are indicated, the technologist may proceed according to established protocol and/or standing orders.

If **any** of the above conditions are indicated, the Radiologist noted below shall determine whether contrast is to be used and, if so, what type and what amount.

Per Dr.		Procedure performed	
Type and volume of contrast used		Injected by	
Radiologist signature	Date	Technologist signature	Date