



Computed Tomography IV Contrast Consent Form

Name _____ Patient # _____ Age _____ Wt. _____

Examination _____ Ref. Physician _____

1. Have you had any previous scans with IV Contrast? YES / NO
2. Have you ever had a reaction to the IV Contrast? YES / NO
3. Do you have any allergies to **ANY** substance? YES / NO

Explain _____

4. Do you have a history of asthma or hayfever? YES / NO
5. Do you have a history of cardiac disease? YES / NO
(Ex: Heart attack, arrhythmia, congestive heart failure, angina valvular disease.)
6. History of sickle cell anemia or blood disease? YES / NO
7. Do you have a history of Diabetes?
If Yes, are you taking Glucophage, Glucovance (Metformin)?

8. Do you have a history of Cancer? YES / NO

Explain _____

9. Do you have a history of Kidney Disease? YES / NO
10. Do you have a history of stroke, seizure or brain tumor? YES / NO
11. Do you have a history of Pheochromocytosis? (Tumor of Adrenal Glands) YES / NO
12. Are you taking any medications? YES / NO

Identify _____

13. Are you pregnant or breastfeeding? YES / NO

Patient's Signature _____ Date _____

TECHNOLOGIST USE ONLY:

Was the patient pre-medicated? YES / NO

Fasting? YES / NO

Contrast injection: Ultravist 300 Lot# _____

Expiration date _____

Additional Notes: