12000 RICHMOND AVE. SUITE #125
HOUSTON, TX 77082
281-720-8688 281-720-7225

MR #: _______________

Computerized Tomography (CT) Consent Form

You have the right to be informed about the recommended diagnostic procedure to be used, so that you may make the decision whether or not to undergo this procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you. It is so that you can choose to give or withhold your consent to the procedure.

If you are pregnant or think you may be pregnant, please inform center personnel at once.

Your physician has requested a Computerized Tomography (CT) examination to obtain additional information. This is a diagnostic test that involves x-ray images and computer to produce an image of internal body parts.

As part of your CT, a contrast agent may be injected into your vein in order to produce better images of the part of the body being examined.

Potential Risks: The following complications are possible anytime an injection is given: potential for pain, bleeding, bruising or swelling at the injection site. CT exams requiring contrast may result in: mild headache, nausea, itching or other vague symptoms for a short time after the injection. Additional allergic reactions in response to the contrast agent may include: hives, shortness of breath or difficulty in swallowing. There have been rare instances of death after the administration of the contrast agent. It is very important that you inform the technologist if you experience any of the conditions mentioned in this form.

If you have previously had a reaction to a contrast injection such as hives, shortness of breath, any significant reaction requiring hospitalization, a history of asthma or other allergic conditions, any history of anemia, sickle cell anemia or kidney disorder; or if you are breastfeeding you must inform the technologist. The safety of contrast in children under 2 has not been established.

The diagnostic test being performed was ordered by your physician based on your symptoms and condition. The benefits of this exam are to assist your physician with a diagnosis.

In conjunction with the American College of Radiology (ACR) guidelines, it is the policy of One Step Diagnostic to identify patients at risk of developing Nephrogenic systemic fibrosis (NSF) prior to any Gadolinium-Based Contrast Agent (GBCA) injection. The method used to identify such patients require assessing renal function at the time of service. Using a point of service device, a serum creatinine level is acquired and used to calculate current estimated Glomerular Filtration Rate (eGFR). If provided, you and/or your insurance company will be billed for this service.

I (WE) CERTIFY THIS FORM HAS BEEN FULLY EXPLAINED TO ME, THAT I (WE) HAVE READ IT, OR HAVE HAD IT READ TO ME (US), THAT THE BLANK SPACES HAVE BEEN FILLED IN AND THAT I (WE) UNDERSTAND ITS CONTENTS. I (WE) HAVE SUFFICIENT INFORMATION REGARDING THE PROCEDURE(S), THE RISKS AND HAZARDS INVOLVED.

Patient Name Printed: ______________________________

Patient Signature: ______________________________

Date: ______________________Time: ________: __________ AM or PM

Witness Name Printed: ______________________________

Witness Signature: ______________________________

Date: ______________________Time: _________: __________ AM or PM

inclusive MRI &Diagnostics
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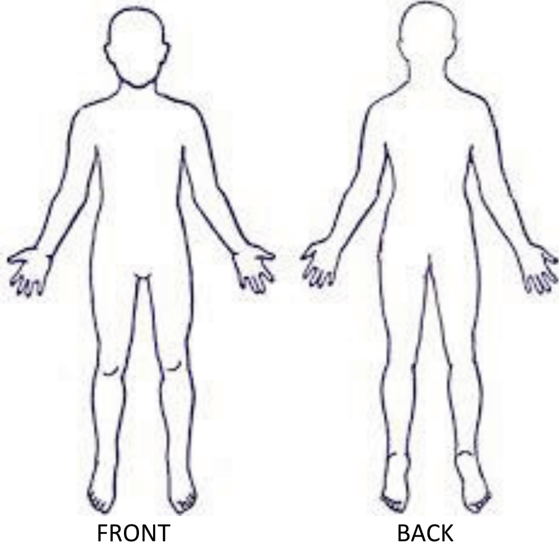
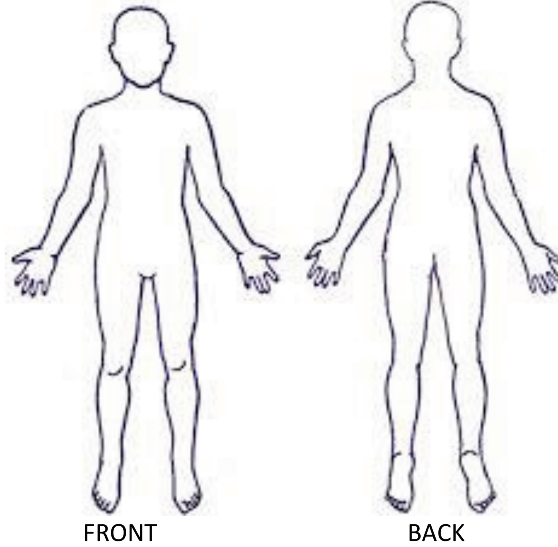
Draw where your **pain or symptoms** are located on the figure below:



Draw the location of **any metal** in your body on the figure below:



Acknowledgement: I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that at this time I am **pregnant OR NOT pregnant** (circle)**.**

_________________________________ ____ ___________________
Patient/Parent/Legal Guardian Signature Technologist Date

***For Clinicians Use Only**

BUN: ____ Creatinine: ____ or **N/A**

Patient Pre-Exam Education Given: **YES** **NO** Patient Shielded: **YES** **NO**

Clinician Providing Contrast Coverage: ____

Contrast Administration:

_________cc of __________________________with a _____________________________ @___________×__________________
(Needle Gauge & Type) (Time) (Number of Punctures)

By: ____ in ____
(Clinician Signature) (Location of Site)

Lot #: ____ Expiration Date: __________________________________

CT Power Injector Used: **YES** **NO** Rate: ________________________________ cc per___________________________ seconds

Contrast Reaction: **YES** **NO**

Patient Discharge Instruction Given: **YES** **NO**

Discharge Instruction for Contrast Extravasation Given: **YES** **NO** **N/A**

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MR #: ________________

CT AND IV CONTRAST HISTORY AND SCREENING FORM

Patient Name: ______________________________ Date: ______________

Sex: **M** **F** Height: ____________ Weight: ____________ DOB: ______________ Age: __________

Referring Physician: ____

Are you pregnant: **YES** **NO** **N/A** Last Menstrual Period: ______________________________

Reason you are here today for an exam:

Explain your medical problem in detail. ***(What happened? Where did it happen? How long have you had this problem?)***

____

____

____

Do you have pain? **YES** **NO** Where? ______________________________

Have you had any surgeries in the area(s) that are being imaged today? **YES** **NO** Where: ______________

Have you taken any medication/sedation/alcohol today to help you relax for this procedure? **YES** **NO**

If yes, please list: ______________________________time taken: ______________

Have you had a previous exam related to this problem? **YES** **NO** If yes, explain: ______________

____

CONTRAST HISTORY: ☐ **APPLICABLE FOR THIS EXAM** ☐ **NOT APPLICABLE FOR THIS EXAM**

Are you taking Metaformine Hydrochloride (Glucophage, Glucovance)? **YES** **NO**

Have you ever had a previous allergic reaction to x-ray contrast (dye)? **YES** **NO**

If yes, explain: ____

____

Do you have any of the following? **(circle, if yes, please explain)**

Yes **No** Asthma ______________________________
Yes **No** Allergic Respiratory Disease ______________________________
Yes **No** Diabetes ______________________________
Yes **No** Kidney Disease ______________________________
Yes **No** Cancer ______________________________
Yes **No** Multiple Myeloma ______________________________
Yes **No** Prostate Problems ______________________________
Yes **No** Are you breast feeding at this time? ______________________________
Yes **No** Dizziness ______________________________
Yes **No** Heart Disease ______________________________
Yes **No** Stroke ______________________________
Yes **No** Liver Disease ______________________________
Yes **No** Seizure Disorder ______________________________
Yes **No** Bladder Disease ______________________________
Yes **No** Headaches ______________________________
Yes **No** Orthopedic Pins/Rods/Screws/Plates/etc. ______________________________

List any drug allergies: ____

List all surgeries in your lifetime: ____

____

List all medications you are currently taking: ____

____

____