CHOICE
Diagnostic Imaging

INFORMED CONSENT FOR IV CONTRAST FOR CT

PLEASE PRINT. THANK YOU!

Patient Name: _____ Date: _____

Type of Exam: _____ Time: _____

I hereby authorize Choice Diagnostic Imaging to administer an injection of an iodine substance, for the purpose of enhancing body organs, for a more complete diagnostic study.

I have been made aware that it is possible to experience an allergic-type reaction to the injection. The most common reactions include: nausea, vomiting, flushing or a generalized feeling of warmth. Other reactions include: hives, chills, fever, severe allergies, sweating, headache, dizziness, weakness, severe retching, sneezing, etc. I understand that adverse reactions have occasionally been reported. For this reason, I understand that well-trained personnel are available to treat me in the event of serious reaction.

I authorize the above to administer any additional medications or treatments deemed necessary to aid in the relief of any reaction.

Notify the technologist or radiologist before signing this form if you are taking Glucophage or Glucovance for diabetes, OR have one more of the following conditions: Sickle Cell Anemia, Multiple Myeloma, or Pheochromocytoma.

I have read and understand the above and agree to the iodine injection.

Patient Signature	Signature of Guardian/Parent If A Minor
Signature of Witness	Relationship to Patient