NORTH JEFFERSON IMAGING

2217 Decatur Hwy, Suite 115

Gardendale, AL 35071

**INFORMED CONSENT FOR CONTRAST AGENT INJECTION**

Your physician has requested for you to have an x-ray examination that requires an injection of a contrast agent. This contrast agent will allow certain organs/structures to be visualized on the x-ray examination.

The contrast agent is administered through a small needle placed within a vein or joint when used in arthrography. The contrast agents are considered to be safe. However, any such injection is associated with a light risk of harm, infection or abnormal reaction to the contrast agent. A mild reaction to the contrast agent, which occurs occasionally, would be sneezing or hives. A serious reaction to the contrast agent, such as anaphylactic shock, is very unusual. Very rarely, death may occur. In the event that any of the reactions occur, there is a licensed physician on site at the time of injection.

Injection of contrast agents may also be associated with side effects, which are not felt to be any allergic reactions. The side effects may include a warm feeling at the time of injection (could be a localized area such as your back, feet or groin), nausea and/or vomiting, and a metallic taste in your mouth. On occasion, a patient will complain of a headache following the injection of a contrast agent. If you suffer from a seizures disorder, there is a less than 1% chance of the contrast agent triggering the onset of a seizure.

**If you have any questions, please as our technologist or our radiologist for clarification.**

I have read and understand the above explanation about the contrast injection and all of my questions have been answered of the x-ray examination and the injection of the contrast agent.

Venipuncture performed by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ for contrast/Creatinine.

Patient Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If patient is a minor or unable to sign, complete the following:

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_