

**Contrast Media Authorization**

Patient Label

Procedure: \_\_\_\_\_

XR#: \_\_\_\_\_

Your doctor has requested an imaging procedure that requires the use of radiographic contrast media which will be injected into your blood stream and allows various internal body parts and systems to be seen during imaging. This contrast solution is associated with potential risks. Most patients experience no adverse or unusual effects from contrast use. An evaluation of your responses to the questions on the "Patient Information Sheet" will help us determine whether you may have a higher risk of a reaction. These questions help determine whether you may be allergic to iodine or need additional interventions. Please inform the technologist if you have ever been allergic to, become sick from, or developed a skin rash from medication containing iodine. Even if you do not fall into this category, you may still experience a reaction.

You may experience a temporary warm sensation, nausea and vomiting, or a strange taste in your mouth. These do not require treatment. Allergic-type reactions, although rare, may include itching, hives, swelling of the lips and eyes, sneezing, shortness of breath. The most severe reactions, which are extremely rare, may include shock, kidney failure, and cardiac arrest.

I feel that I have adequate knowledge and sufficient time upon which to base my consent to the procedure and the use of contrast media. I have had an opportunity to ask questions, and they have been answered to my satisfaction. I herein consent to the procedure and use of contrast media.

\_\_\_\_\_  
 Signature of patient or representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Time

\_\_\_\_\_  
 Relationship to patient

\_\_\_\_\_  
 Interpreter (if utilized)

\_\_\_\_\_  
 Witness

\_\_\_\_\_  
 If telephone consent, second witness

**\*\*If unable to obtain patient authorization, the referring physician gives approval to proceed with IV contrast.\*\***

\_\_\_\_\_  
 Physician Signature

\_\_\_\_\_  
 Date/Time