CLARKSVILLE IMAGING CENTER

CONTRAST HISTORY FORM

Patient: _____ Age: _____ WT: _____ Xray # _____

Exam: _____ Referring MD: _____

History: _____

Pregnancy: _____ NO _____ YES Breast feeding: _____ NO _____ YES

_____

Allergies: _____ NO _____ YES

_____

Previous Contrast Reaction: _____ NO _____ YES

Symptoms: Shock Laryngeal edema Hives

Upper Respiratory Rash Other: _____

Treatment: _____

Contrast Pre-medication _____ NO _____ YES

Asthma: _____ NO _____ YES

CHF (Congestive Heart Failure): _____ NO _____ YES

Sickle Cell Disease: _____ NO _____ YES

Renal Disease: _____ NO _____ YES

Kidney Tumor or Hx of one kidney: _____ NO _____ YES

Personal Hx of Renal Failure: _____ NO _____ YES

Diabetes: _____ NO _____ YES

Are you taking Glucophage/Metformin/Glucovance _____ NO _____ YES

Patient is aware to be off Glucophage (metformin) x 48 hours _____ NO _____ YES

Smoker: _____ NO _____ YES _____ YRS. _____ QUIT

Hx of Multiple Myeloma: _____ NO _____ YES

Other: _____

Creatinine: _____ Date: _____ BUN: _____ Date: _____

CT examinations often require the use of contrast materials to enhance the visibility of certain tissues or blood vessels. The contrast material may be given as an oral drink and/or injected intravenously during your exam. In rare cases, the contrast material may be needed to be given in the form of an enema to help visualize the lower colon in the pelvis. The intravenous contrast material contains IODINE and some individuals may be allergic. We screen all patients prior to administering this contrast material. We use non-ionic contrast material which is proven to be more tolerable. Some reactions such as nausea, vomiting, skin rash, hives, or other more severe reactions such as death can occur, but are very uncommon. With the safety of the new non-ionic contrast materials, adverse effects are very rare. In addition there is risk of this contrast leaking into the tissues surrounding the injection site. This may produce bruising, swelling, irritation, and possibly an infection to the surrounding tissue.

I have answered the questions to the best of my knowledge and understand the information presented to me.
I consent to the use of I.V. contrast during my exam.

Patient, Parent, or Guardian Signature _____ Date: _____

Contrast Used: _____ cc's injected: _____

CLARKSVILLE
IMAGING
CENTER
OPEN MRI • CT • ULTRASOUND

2320 Wilma Rudolph Blvd.
Clarksville, TN 37040
(931) 245-OPEN(6736)
Fax (931) 245-6738

Patient Name_____

Medical Record # _____

CONSENT FOR CONTRAST MEDIUM DIAGNOSTIC PROCEDURE

1. I hereby request and authorize Clarksville Imaging Center and their medical staff to perform the following Diagnostic Procedure: _____

2. I understand the above named diagnostic procedure has been ordered by my physician, _____ _____.

3. I have been informed of the risks and possible consequences involved, and that unforeseen results may occur.

4. I have read and fully understand this entire consent form.

5. I further acknowledge that all the above blank spaces have either been completed or crossed off prior to my signing.

Signed: _____ Date: _____

(Patient or Nearest Relative)

HISTORY

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ initial

CONSENT FOR CONTRAST MEDIUM DIAGNOSTIC PROCEDURE