Health
South Western Sydney
Local Health District

Site: Fairfield Hospital

CONSENT FOR CONTRAST EXAMINATIONS

SURNAME	MRN
OTHER NAMES	☐ MALE ☐ FEMALE
D.O.B. _____/_____/_____	M.O.
ADDRESS	
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

Your doctor has asked us to perform an examination which requires the injection of contrast (x-ray dye). When contrast is used, it is injected directly into a vein and may cause a mild warm sensation that can last for one to two minutes.

In the Radiology Department at Fairfield Hospital we use a non-ionic contrast. Side affects are very uncommon with this contrast, however a minimal risk still exists.

Mild temporary reactions include nausea, vomiting, itching and hives, which all respond quickly to medication. Less frequently, asthma-like affects may occur and very rarely, life threatening reactions may require hospital treatment.

PATIENT QUESTIONNAIRE

1. Have you ever had a CAT scan, angiogram or x-ray where you received an injection of contrast? ☐ Yes ☐ No
2. If 'Yes', did you have any problems or reactions from this injection? ☐ Yes ☐ No
3. Are you ALLERGIC to anything? (e.g. medication, food, bee-stings, Iodine, seafood, shellfish, etc) ☐ Yes ☐ No

If 'Yes', please specify _____

_____

4. Are you pregnant? ☐ Yes ☐ No
5. Do you have a history of:
   - (a) Kidney Disease ☐ Yes ☐ No
   - (b) Heart Disease ☐ Yes ☐ No
   - (c) Asthma ☐ Yes ☐ No
   - (d) Diabetes ☐ Yes ☐ No
   - (e) Myeloma ☐ Yes ☐ No

   If you HAVE diabetes, do you take any of the following medication:
   - (i) Glucophage ☐ Yes ☐ No
   - (ii) Diabex ☐ Yes ☐ No
   - (iii) Diaformin ☐ Yes ☐ No
   - (iv) Metformin ☐ Yes ☐ No

CONSENT

I have read and understood the above information. I have answered the questions truthfully and to the best of my knowledge.

I understand the risks involved with the non-ionic contrast. I consent to the administration of the contrast for my x-ray examination.

Name: _____ *(patient/client/parent/guardian)* Relationship: _____ *(parent/guardian/etc)*

Signature: _____ Date: _____

Name: _____ *(health professional)* Designation: _____

Signature: _____ Employee No.: _____ Date: _____

BINDING MARGIN – NO WRITING

FILE IN CLINICAL RECORD

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