

Patient Sticker



MRI CONTRAST CONSENT

Your physician has referred you for an examination during which you will receive an injection of Gadolinium contrast material into a vein. Adverse reactions can occur in up to 2.4% of patients. The most common reactions are nausea, headache, dizziness, rash and hives. These reactions are generally transitory and abate within 24 hours. More serious sensitivity reactions, such as anaphylactic shock, are rare occurrences and medication is readily available to treat these conditions. There is an extremely rare complication called Nephrogenic Systemic Fibrosis (NSF) that has been reported with MR Contrast in patients who have a history of Renal Failure, particularly those who require dialysis. Please notify your technologist if you have any history of kidney disease. There is currently no known risk for this disease in the absence of kidney disease. We recommend that you notify your primary care provider should you experience any type of contrast reaction.

Please notify the technologist if you are pregnant, breast feeding, have liver or kidney disease, or have anemia or diseases that affect the red blood cells. Any previous reactions to MRI contrast material or other medications should also be reported before injection. While this information may concern you, we believe it to be in your best interest to be informed and to understand what is involved. Naturally, you may refuse permission to perform this test or you may change your mind before the procedure. It is worth knowing that the risk of any serious complication is extremely small.

PLEASE ANSWER THE FOLLOWING:

- Yes _____ No _____ Were you prescribed any special pre-medication for today's study?
If Yes, name of medication _____
- Yes _____ No _____ Do you have Asthma or Emphysema?
- Yes _____ No _____ Have you had MRI IV contrast media before? If Yes, how many? _____
- Yes _____ No _____ Did a contrast reaction occur during a previous exam in MRI or CT?
If Yes, please explain _____
- Yes _____ No _____ Are you breast-feeding?
- Yes _____ No _____ Do you have general allergies (hay fever, dust, mold, dander, food)?
- Yes _____ No _____ Do you have any drug allergies? Please list: _____
- Yes _____ No _____ I have received a Multihance / Prohance Patient Medication Guide for review.

I have read and understand the above information. I have had my questions answered to my satisfaction and give my consent to have the exam performed. I understand that in spite of every skill and effort made to avoid complications during the examination, occasional complications do occur. I understand that I have the right to refuse any portion of this procedure.

Patient/Representative Signature _____ Date _____

If not the patient, please indicate relationship _____

Reviewed By (Technologist Signature): _____

TECHNOLOGIST TO COMPLETE THIS SECTION

Contrast Injection Time: _____

Contrast Agent: _____ Lot # _____ IV Started By: _____

_____ Hand Injection: Volume Used _____ ml IV Site: _____

_____ Injector: Volume Used _____ ml IV Gauge: _____

Waste _____ ml IV DC'd By: _____

Technologist: _____

Contrast Reaction _____ No _____ Yes Radiologist on site: _____