Small label

Consent to Undergo CT with Intravenous Injection of Contrast Agent

You need to have a CT scan that requires the intravenous (IV) injection of a contrast agent. It is a solution containing iodine that helps diagnose diseases in different parts of the body.

Before injection of the contrast agent, you need to be aware of the risks related to injection of the contrast agent (iodine).

When receiving the IV injection of the contrast agent, you may experience a warm feeling throughout your body and a metallic taste in your mouth. Sometimes, nausea and even vomiting. Very few patients develop an allergic reaction and may develop hives (urticaria). This side effect generally resolves on its own or after medication is provided.

1 in every 5,000 patients may develop difficulty breathing (shortness of breath) or swelling of the face. These complications will be treated immediately with the appropriate medications.

A severe allergic reaction occurs in 1 in 4,000 patients. This complication may be life-threatening. It is very rare, and there is no way to predict it in advance.

IV contrast agents are generally tolerated by the vast majority of patients, without any side effects.

Please answer the following questions:

1. Are you allergic to iodine? ☐ No ☐ Yes
2. Have you been injected with a contrast agent before? ☐ No ☐ Yes
3. Are you allergic to any medications, foods, flowers or plants? ☐ No ☐ Yes
4. Do you have asthma or other respiratory issues? ☐ No ☐ Yes. If so, did you receive premedication before the exam? Specify: _____
5. Do you have diabetes? ☐ No ☐ Yes. If so, do you take insulin or do you take Glucophage or another oral medication? ☐ No ☐ Yes _____
6. Do you have a history of heart disease? ☐ No ☐ Yes _____
7. Do you have kidney disease? ☐ No ☐ Yes
8. Are you pregnant? ☐ No ☐ Yes

To consent:

I hereby declare and confirm that the side effects of the contrast agent have been explained to me. I was informed that at times immediate treatment is required due to side effects, and I consent to receive such treatment if necessary.

_____	_____	_____
Date	Patient's name	Signature of patient/guardian

To refuse:

I refuse to undergo the test with injection of an iodine contrast agent, and I am aware that due to my refusal, the quality of the scan is negatively impacted.

_____	_____	_____
Date	Patient's name	Signature of patient/guardian