MRI CONTRAST CONSENT FORM

PT NAME:_____

PT DOB: _____

HEIGHT:_____ **WEIGHT:**_____

MRN:_____

ACCESSION:_____

Your doctor has scheduled you for a MRI examination that requires an injection of a contrast agent in your bloodstream. The contrast agent, also called contrast media, contrast material or MRI dye assists the radiologist in interpreting your MRI scan. The contrast media being injected contains gadolinium. If you are allergic to gadolinium, please inform the technologist.

The contrast media is given through a small needle placed into a vein, usually on the inside of your elbow or on the back of your hand. Normally, contrast media is considered quite safe. However, an injection carries slight risk of harm including injury to the skin, a nerve, artery, or vein. An infection or reaction to the material being injected can also occur. Occasionally, a patient will have a mild reaction to the contrast agent or develop sneezing or hives. Uncommonly (one case in a thousand) a serious reaction to the contrast occurs. Our physicians and staff are trained to treat these reactions. Very rarely (1:100,000) death has occurred related to contrast administration. The risk of a severe consequence is similar to that of administration of penicillin.

Certain patients are at a higher risk for experiencing a reaction to the contrast agent. However, these newer agents are not absolutely free of reactions, even serious ones.

Patients who are at higher risk for adverse effects of contrast are patients:

- Who have already had a moderate or severe “allergic-like” reaction to contrast material which required medical treatment or hospital treatment.
- With severe allergies or asthma currently receiving drug treatment
- With severe kidney failure, particularly caused by diabetes

Have you ever had:	YES	NO	Explanation:
Gadolinium IV Contrast			
Allergic Reaction to IV contrast			
Diabetes			
Heart Disease			
Kidney Disease			

Your signature on this form indicates that you have read and understand the information provided in this form and that you authorize and consent to the performance of the procedure.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

TECHNOLOGIST ONLY:

LABS:

BUN: _____ Creatinine: _____ eGfr: _____ Date of Labs: _____

Contrast Media: _____ Dose _____

Lot Number: _____ Exp Date: _____

IV gauge: _____ Site: AC Forearm Hand Side: R L

History: _____

Cholecystectomy Appendectomy Hysterectomy (FULL / PARTIAL) Other:_____

_____