St. Elizabeth HEALTHCARE

MRI CONTRAST INJECTION
INFORMED CONSENT

Originated: Revised: 06/09, 05/11, 03/12, 04/12
Medical Record File No.: RAD M-11 Form No.: 10307 SEH

Your physician has referred you to our facility for a Magnetic Resonance Imaging ("MRI") examination. In certain cases, an injection of contrast solution is used to enhance the MRI images and provide your physician with valuable diagnostic information. This contrast solution is different from the type used for X-rays. It will be injected into your vein and helps make the MRI examination more effective by enhancing certain physical areas of interest. Although the contrast solution used for MRI examinations has proven to be very safe and has been approved by the U.S. Food and Drug Administration, you need to know that allergic reactions can sometimes occur. Reactions such as headaches, nausea, and vomiting can occasionally occur and other, more severe reactions, are extremely rare, but could occur, including respiratory distress, shock, or even death. While such reactions are extremely rare, the risk that they might happen cannot be totally ruled out. Your physician is aware of these risks and feels that the information that will be obtained from the MRI examination outweighs any such risk. In addition, during the course of the MRI examination, conditions may necessitate additional or different treatment than the treatment you originally consented to undertake. The technologist and/or the physician here at our MRI facility will gladly discuss this procedure with you and answer any questions that you might have.

By signing below, you agree that the following statements are true and that we can rely on them:

- I am aware that the injection of contrast solution may be a part of my MRI examination.
- I have been informed that allergic reactions to such contrast solution can happen on rare occasions.
- I have been given the opportunity to ask any questions related to my scheduled MRI examination and possible injection of contrast solution.
- I am authorizing the physicians and other personnel of your MRI facility to treat me in the event of an allergic reaction. I understand that this treatment may include medications or medical devices, which may be required for the protection of my health or life.
- If at any time after I leave your MRI facility I do not feel well, I understand that it is important for me to contact my personal physician. I also understand that if my personal physician has any questions about the contrast solution given to me, they will need to contact the facility where my MRI was conducted.

Please check "Yes" or "No" to the following conditions and enter weight:

❒ Yes ❒ No Diabetes
❒ Yes ❒ No Blood Disorders &/or Sickle Cell Anemia
❒ Yes ❒ No Renal (Kidney) Disease, renal cancer, transplants
❒ Yes ❒ No Lupus or Collagen Vascular Disease
❒ Yes ❒ No Clinical Diagnosis of High Blood Pressure
❒ Yes ❒ No Under Current Treatment for High Blood Pressure (Hypertension)
❒ Yes ❒ No Allergies to medications; if so what types of reactions _____
❒ Yes ❒ No Liver Disease
❒ Yes ❒ No Multiple Myeloma
❒ Yes ❒ No Pregnancy
❒ Yes ❒ No Breast-Feeding **
❒ Yes ❒ No Asthma

Weight: _____
Form completed by: Patient ____ Relative/POA ____

Signature of Patient/POA/family member: _____

Please list a phone number if family/POA for verification_____ Date: ___/___/___

If verbal consent 2 medical signatures must be obtained:

First Signature: _____ Second Signature: _____ Date: ___/___/__
** It is the policy of St. Elizabeth that all breastfeeding patients may want to refrain from breast feeding for 24 to 48 hours after receiving a contrast injection**

For Official Use Only:
Creatinine Level: _____ Normal Range: _____
GFR: _____
Contrast Brand: _____
Dose: _____

Comments:
Lot#:
Expiration Date:

Technologist Signature: _____ Date: _____ Time: _____