Lexington Clinic
Since 1920

INFORMED CONSENT FOR CT/IVP PROCEDURE

Your doctor has scheduled you for a CT/IVP exam an that requires the injection of a contrast media into your bloodstream. The contrast media injection allows for better detailed imaging of certain structures inside your body.

The newer non-ionic contrast media has been chosen for intravenous use at Lexington Clinic. Although these agents have been shown to be safer than the previously used contrast media, any injection carries some risks. Approximately 95% of all reactions to the contrast media are mild to moderate in nature and may include itching, hives, and swelling of the lips and eyes. Some respiratory and cardiac reactions may be more serious and require medical treatment. These problems are usually recognized promptly and treated without difficulty. The risk of death (1 out of every 100,000 exams) is no greater than that from an injection of penicillin. On rare occasions, the contrast media could leak out of the vessel and cause skin inflammation.

Although the CT/IVP procedure and contrast media injection is very safe, we believe it to be in your best interest to understand what is involved. **You are asked to sign this form to verify that you understand the indications and possible complications of this procedure. It is also important to inform the technologist of any medical conditions, including pregnancy, prior to the exam.** You will have ample opportunity to discuss any questions you may have regarding your CT/IVP exam.

In addition, this newer and safer contrast media is not covered under some health insurance plans. Please be advised that the cost of the contrast media will be the patient's responsibility in the event that your insurance provider does not cover it.

The risks involved and the possibility of complications if pregnant during this procedure have been explained to me.

I acknowledge that:

- ☐ **I am pregnant.**
- ☐ **I am not pregnant.**
- ☐ **There could be a possibility that I could be pregnant.**

Known allergies/Medical conditions. _____

_____

Your signature on this form indicates your consent for this procedure.

Patient Name _____ Clinic Number _____

Patient Signature _____ Date _____/_____/_____

Parent/Guardian _____ Date _____/_____/_____

CT/IVP Technologist _____ Date _____/_____/_____

Referring Physician _____ Date _____/_____/_____