



AUTHORIZATION AND CONSENT TO USE CONTRAST MEDIA

I authorize _____, to administer a contrast agent
(Radiologic Technologist)
_____ to _____
(contrast agent used) (name of patient)

as part of a diagnostic imaging procedure.

The administration of this contrast agent will usually allow visualization of organs and tissues not ordinarily visible without this contrast.

I understand the common complications to be generally minor; these include itching, hives and rash. Although rare, serious complications are possible as well, including shortness of breath, shock, cardiac arrest, convulsions and death.

If complications should occur, I understand that I will be given prompt medical attention by a qualified physician who will be available at all times during the procedure.

I have had an opportunity to ask all questions that I have regarding this study and all of my questions have been answered satisfactorily.

I understand that my participation in this diagnostic study is voluntary and that I may withdraw whenever I choose.

I have read and understand the information stated above and I sign this consent willingly.

Signature of Patient Date Time

Witnessed by Technologist Date Time

I am unable to read, but this consent has been read and explained to me by:

(name of reader)

I understand the information stated above and I sign this consent form willingly.

Signature of Patient Date Time

Witnessed by Technologist Date Time