PARAMAGNETIC CONTRAST ADMINISTRATION CONSENT FOR MAGNETIC RESONANCE IMAGING (MRI)

I hereby request and authorize the technologist of Corridor Radiology to utilize paramagnetic contrast in accordance with the instruction of the referring physicians and/or radiologist. I have been informed by the technologist and/or physician of the nature of the procedure, the indications for the utilization of paramagnetic contrast to help facilitate a specific diagnosis and any possible adverse reactions associated with this injection including: headache, nausea, dizziness, elevated or lowered blood pressure, allergic reactions, which vary rarely could lead to coma or death. Certain patients are at a higher risk for experiencing a reaction to the contrast medium.

Place an X on the appropriate line below if you have ever had a:

Yes No
1. History of moderate or severe “allergic-like” reaction to MRI contrast medium, which required treatments.
2. History of allergies: (specific) ________________________________
3. History of asthma. Have you had an attack within the last 72 Hours? Y N
4. History of Diabetes, kidney disease, or on dialysis
5. Are you breast feeding? (must discontinue breastfeeding for 48 hours)

Signature of Patient/Legal Representative ________________________________________________
Relationship to Patient _________________________________________________________________
Signature of Witness ________________________________________________________________
Date _______________

Refusal of Contrast

After reading the information, I wish to refuse the injection of paramagnetic contrast.

Signature of Patient/Legal Representative ________________________________________________
Relationship to Patient _________________________________________________________________
Signature of Witness ________________________________________________________________
Date _______________