



INFORMED CONSENT FOR X-RAY & FLUOROSCOPY

PATIENT NAME: _____ MED REC #: _____

TO THE PATIENT: You have the right to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involve. This disclosure is not meant to scare or alarm you. It is so that you may choose to give or withhold your consent to the procedure.

If you are pregnant or think that you may be pregnant, please inform the center personnel at once.

Your physician has requested that we perform an x-ray to obtain additional information. X-ray produces images of the internal body parts being examined. X-ray is painless, however, radiation is emitted. Therefore, it is critical for you to inform center personnel if there is any possibility you could be pregnant. Because the x-ray is a diagnostic procedure, it provides information that may aid your physician in diagnosing and treating your medical condition. Without the x-ray, accurate diagnosis and proper treatment may be delayed.

During some fluoroscopic procedures, a contrast agent may be injected into your vein in order to produce better images of the part of your body that is being examined.

POTENTIAL RISKS – The following complications are possible anytime an injection is given, there is potential for pain, bleeding, bruising or swelling at the injection site. Exams requiring contrast may result in a mild headache, nausea, itching or other vague symptoms for a short time after the injection. Additional allergic reactions in response to the contrast agent may include hives, shortness of breath or difficulty swallowing. There have been rare instances of death after the administration of the contrast agent. It is very important to inform the technologist if you experience any of the conditions mentioned in this form.

NOTE TO PATIENTS: If you previously had a reaction to a contrast injection such as hives, severe itching, shortness of breath and/or any significant reaction requiring hospitalization, a history of asthma, or other allergic conditions any history of anemia, sickle cell anemia, or kidney disorder, are pregnant or breast feeding you **MUST** inform the technologist.

There may be other imaging alternatives; however, your physician believes the x-ray to be the best diagnostic test for you, considering your symptoms and conditions. The benefit of this exam is to assist your physician with a diagnosis.

I (WE) CERTIFY THIS FORM HAS BEEN FULLY EXPLAINED TO ME, THAT I (WE) HAVE READ IT OR HAVE HAD IT READ TO ME, THAT THE BLANK SPACES HAVE BEEN FILLED IN AND THAT I (WE) UNDERSTAND ITS CONTENTS. I (WE) HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS ABOUT MY CONDITION, ALTERNATIVE FORMS OF TREATMENT, THE PROCEDURES TO BE USED, AND THE RISKS AND HAZARDS INVOLVED AND I (WE) BELIEVE THAT I (WE) HAVE SUFFICIENT INFORMATION TO GIVE THIS INFORMED CONSENT.

Patient/Parent/Legal Guardian Signature

Date

Witness Signature

Date

X-rayConsent5.31.00