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Information for Administration of Contrast Medium

Patient's SurnameUMRN..... Christian Name Address..... Sex..... DOB Age..... USE STICKER WHEN AVAILABLE	OFFICE USE ONLY Serial No. Label
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The investigation you have been referred for may require an injection of x-ray contrast medium. This contrast medium improves the detection of abnormalities in the body and without its use, significant abnormalities may remain undetected.

During injection most patients report a transient feeling of warmth or a metallic taste in the mouth.

However, as with all drugs, side effects and adverse reactions are possible. Minor reactions usually consist of itching and facial swelling. More severe reactions can result in shortness of breath and low blood pressure. It is very rare for reactions to be life threatening, less than 1 in 100,000.

In this Radiology Department, we use the latest contrast media where side effects and adverse reactions are kept to a minimum and our staff are trained to deal with any side effects.

More serious adverse reactions are usually related to an allergy to contrast media. To reduce the risk of reactions, please answer the following questions:

- Have you had a previous reaction to x-ray contrast media? YES / NO
- Are you allergic to other drugs, bee stings, have eczema or asthma? YES / NO
- Do you have poor kidney function? YES / NO
- Are you breastfeeding? YES / NO
- Are you on **any** Diabetic medications? YES / NO

If you have any concerns, please raise them with a staff member prior to your study.

Patient Acceptance of Injection of Contrast Medium

I have read and understood the above information. I give my permission to have an x-ray contrast injection as part of my examination.

Patient Name: _____ Date: _____

Patient Signature: _____
Or legal guardian

Interpreter's Signature: _____
If required

Medical Officer authorises contrast injection, if the patient is unable to sign or has had a previous allergic reaction or other

Medical Officer Signature: _____