



INFORMED CONSENT

CONSENT FOR TREATMENT

CONSENT FOR MEDICAL PROCEDURE AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

State law requires us to obtain consent to your contemplated diagnostic or medical procedure. Please read this carefully. Ask about anything you do not understand. We are pleased to explain or contact your physician if necessary.

1. I hereby authorize and direct Envision Imaging of Acadiana to perform upon (Name of Patient or Myself) \_\_\_\_\_ the following diagnostic or medical procedure \_\_\_\_\_.

This authorization also includes any necessary or advisable anesthesia, administration of any medicine or drugs deemed necessary by the radiologist preliminary to, during or following said procedure, including drugs for sedation.

I further authorize the doctors to perform any other procedure that in their judgement is advisable for my well being. This procedure has been explained to me. Alternate methods of treatment, if any, have also been explained to me, as have the advantages and disadvantages of each. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of surgery or as to cure.

2. In general terms, the nature and purpose of this operation or medical procedure is:

- Inject or administer MRI Contrast, Non-Ionic Contrast (x-ray dye containing Iodine) and/or Radiopaque substances for the purpose of image enhancement and diagnostic testing.
- The use of oral, intramuscular and/or intravenous administration of drugs to dull or reduce the intensity and awareness of pain and allow me to tolerate procedures by relieving anxiety, discomfort, or pain.

3. Some possible risks known to be associated with these procedures, including anesthesia are: loss of function of organ, brain damage, loss of function of arm or leg, quadriplegia, paraplegia, localized burning sensation, substernal chest pain, fever, weakness, generalized coldness, local edema, facial edema, scieral edema, constipation, aspiration, regional lymphangitis, renal damage and rarely severe allergic reaction (characterized by cardiovascular, respiratory and cutaneous symptoms), reactions which could result in death or disability.

- Injection site symptoms: Pain, warmth, local irritation, burning, vein inflammation, soft tissue damage, contrast infiltration.
- Headaches, nausea, vomiting, infection, bleeding, seizures, neck/arm/back/leg pain, urinary retention, mental confusion, contrast reactions, nerve damage, and paralysis.
- Infection, bleeding, perforated bowel, Pneumothorax.
- Risks from use of medication are: allergic reaction, drug side effects, breathing difficulties, cardiac dysrhythmia, reversible or permanent brain damage, or death.

I hereby authorize and direct the physicians of Envision Imaging of Acadiana and associates or assistants to provide such additional services as they may deem reasonable and necessary including but not limited to the administration of any anesthetic agent, or services of the x-ray department or laboratories, and I hereby consent thereto.

**I hereby state that I have read and understand this consent and that all questions about the procedure or procedures have been answered in a satisfactory manner by my physician, and that all of the above were filled in prior to my signature. This consent form is valid until revoked by me in writing.**

Date/Time \_\_\_\_\_ Signature of Patient\* \_\_\_\_\_

Witness \_\_\_\_\_ Signature of other than Patient\* \_\_\_\_\_

\* To be signed by parent or person legally authorized to consent for the patient.



**HISTORY FORM**

**EXAM INFORMATION**

MRI    CT    w/o Contrast    w/wo Contrast    w/ Contrast (Attach informed consent/ patient education form)

Exam Description \_\_\_\_\_

**PATIENT INFORMATION**

Patient Name \_\_\_\_\_ DOB \_\_\_/\_\_\_/\_\_\_    Male    Female

Drug Allergies \_\_\_\_\_ Weight \_\_\_\_\_ lbs

**MEDICAL HISTORY**

Clinical History \_\_\_\_\_

\_\_\_\_\_

Surgical History \_\_\_\_\_

\_\_\_\_\_

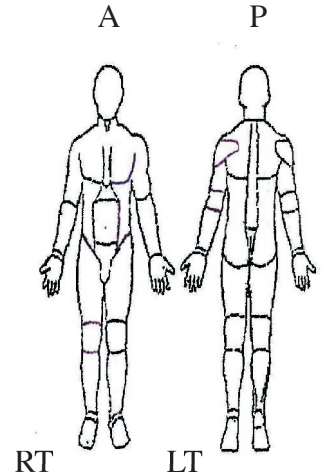
Cancer History \_\_\_\_\_

\_\_\_\_\_ Diagnosed: \_\_\_/\_\_\_/\_\_\_

Chemo Therapy    Yes    No   Date Completed: \_\_\_/\_\_\_/\_\_\_

Radiation Therapy    Yes    No   Area \_\_\_\_\_ Date Completed: \_\_\_/\_\_\_/\_\_\_

Prior Exams \_\_\_\_\_ Location \_\_\_\_\_



**SCREENING**

**MRI**

Yes	No	
<input type="radio"/>	<input type="radio"/>	Pacemaker or Pacer Wires?
<input type="radio"/>	<input type="radio"/>	Cerebral Aneurysm Clips/Coils?
<input type="radio"/>	<input type="radio"/>	Neuro or Bone Growth Stimulators?
<input type="radio"/>	<input type="radio"/>	Ear surgery/Cochlear Implants/Hearing Aid?
<input type="radio"/>	<input type="radio"/>	Stents ≤ 6-8 weeks ago?
<input type="radio"/>	<input type="radio"/>	Penile Prosthesis / IUD?
<input type="radio"/>	<input type="radio"/>	Pain Management Pump?
<input type="radio"/>	<input type="radio"/>	Any metal in your body that you know of? (shrapnel etc.)
<input type="radio"/>	<input type="radio"/>	Were you ever a machinist or welder?
<input type="radio"/>	<input type="radio"/>	Tattoos/Permanent Make-up/Body Piercing(s)?
<input type="radio"/>	<input type="radio"/>	Any possibility of pregnancy?

**CT**

Yes	No	
<input type="radio"/>	<input type="radio"/>	Allergic reaction to contrast?
<input type="radio"/>	<input type="radio"/>	Allergic to Iodine?
<input type="radio"/>	<input type="radio"/>	Diabetic?
<input type="radio"/>	<input type="radio"/>	Renal Failure?
<input type="radio"/>	<input type="radio"/>	Heart Failure?
<input type="radio"/>	<input type="radio"/>	Sickle Cell Anemia?
<input type="radio"/>	<input type="radio"/>	Multiple Myeloma?
<input type="radio"/>	<input type="radio"/>	Asthma?
<input type="radio"/>	<input type="radio"/>	Currently breast feeding?
<input type="radio"/>	<input type="radio"/>	Any possibility you could be pregnant?

I have answered these questions to the best of my knowledge and understand the information presented to me.

Patient/Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Technologist/Witness Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_