FAIR LAWN IMAGING

Patient Name: _____ MRN: _____ Date:_____

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 involved. 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 you may be pregnant, please inform the center personnel at once.

Your physician has requested that we perform a computerized tomography (CT) to obtain additional information. This is a diagnostic test that involves x-ray images and computer to produce an image of internal body parts. As part of your exam a contrast agent may be injected into your vein in order to produce better images of the part of the body being examined.

Potential Risks: The following complications are possible any time an injection is given, there is potential for pain, bleeding, bruising, or swelling at the injection site. 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 that you inform the technologist if you experience any of the above conditions mentioned in this form.

NOTE TO PATIENTS: If you have 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 or if you are taking Glucophage you MUST inform the technologist.

An alternative to this procedure may be an ultrasound, x-ray, MRI or no treatment. However your physician believes the CT to be the best diagnostic test for you, considering your symptoms and condition. 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, AND THAT I (WE) UNDERSTAND ITS CONTENTS.

I (WE) HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS ABOUT MY CONDITION, ALTERNATIVE FORMS OF ANESTHESIA AND 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.

_____DATE:_____TIME:_____
PATIENT/PARENT/LEGAL GUARDIAN SIGNATURE

_____DATE:_____TIME:_____
WITNESS SIGNATURE