

BAY COLONY

Date of Birth: _____

Referring Physician: _____

Sedation/Anesthesia Consent

Exam: MRI Knee Right

Consent for Sedation/Anesthesia

You have the right to be informed about your condition and the medical, surgical, or diagnostic procedure recommended by your physician so that you can make the decision whether or not to undergo the procedure after knowing the risks involved. This disclosure is not meant to alarm you, but simply an effort to make you better informed so you may give or withhold your consent to the procedure(s).

I understand and consent to the administration of Intravenous/oral sedation/Intramuscular Injection that will be administered by my physician and/or his/her associates for my procedure. I realize that the anesthesia may have to be changed, possibly without explanation to me. I understand that certain complications may arise from the use of sedation/anesthetics. The possible risks are minor discomfort, allergic reactions, infection, drug reactions, paralysis, brain damage, breathing or respiratory distress, injury to vocal cords, teeth, eyes, or even death. I understand that for 24 hours following my examination, that I will not drive any motor vehicle, operate machinery, consume alcohol, or sign any legal documents.

Initials _____

Do you have a history of the following? Please circle Yes or No.

- Yes No Previous exam with contrast injection
Yes No Previous side effects/reaction to the contrast
Yes No Kidney Problems or Liver Problems
Yes No Drug Allergies Please List: _____
Yes No Severe Allergic Reactions
Yes No Asthma
Yes No Heart Disease or Heart Surgery
Yes No High Blood Pressure
Yes No Emphysema
Yes No Diabetes
Yes No If diabetic, do you take Glucophage or metformin hydrochloride?
Yes No Multiple Myeloma
Yes No Sickle Cell Disease
Yes No Pheochromocytoma

Women Only:

- Yes No Is it possible that you may be pregnant?
Date of your last menstrual period _____
Yes No Are you breastfeeding?

I certify that I have carefully read and understand the above information, have received my own copy, and give my informed consent to the procedure(s) indicated. I am aware of the possibilities and accept all responsibility for any such reaction and/or complication.

Patient Signature (or Guardian) _____
Date _____
Witness _____
Date _____

BAY COLONY

Date of Birth: _____

Referring Physician: _____

Contrast Consent

Consent for Administration of Contrast

Your procedure today requires the use of an injection contrast material. Please read the following discussion.

A small percentage of patients may develop a reaction to the contrast injection. Symptoms such as a metallic taste, warm sensation all over the body, headache, nausea, and rarely vomiting are usually temporary, and generally do not require any treatment.

"Minor" reactions such as sneezing, red eyes, runny nose, and itching indicate mild allergic reaction and are generally not life threatening. Swollen tongue, difficulty breathing, generalized itching, anaphylactic shock, and brain damage indicate **"Major"** reactions which are serious, require treatment, and may be life threatening. These reactions can occur from iodine compounds or from other solutions used in the procedure when administered by mouth, in veins, arteries, organs, and with and/or around the spinal canal. The risk of developing **"Major"** reactions is much less if you have never had problems with contrast injection in the past. Please inform your physician of any previous allergic reaction. Another risk includes extravasation of the contrast material into the surrounding tissue which could cause skin sloughing or ulceration requiring hospitalization and surgery.

Do you have a history of the following? Please circle Yes or No.

- Yes No Previous exam with contrast injection
Yes No Previous side effects/reaction to the contrast
Yes No Kidney Problems or Liver Problems
Yes No Drug Allergies Please List: _____
Yes No Severe Allergic Reactions
Yes No Asthma
Yes No Heart Disease or Heart Surgery
Yes No High Blood Pressure
Yes No Emphysema
Yes No Diabetes
Yes No If diabetic, do you take Glucophage or metformin hydrochloride?
Yes No Multiple Myeloma
Yes No Sickle Cell Disease
Yes No Pheochromocytoma
Yes No Cancer Comments: _____

Women Only:

- Yes No Is it possible that you may be pregnant?
Date of your last menstrual period _____
Yes No Are you breastfeeding?

To the best of my knowledge, I am not pregnant, and I release Fairmont Diagnostic Center & Open MRI, Inc. from all responsibility in connection with possible pregnancy with respect to any examination ordered by my physician.

I consent to receiving the contrast above mentioned. Initials _____

If an allergic reaction occurs, I consent to required treatment and agree to a driver to take me home with no driving for 8 hours. Initials _____

I certify that I have carefully read and understand the above information, have received my own copy, and give my informed consent to the procedure(s) indicated. I am aware of the possibilities and accept all responsibility for any such reaction and/or complication.

Patient Signature (or Guardian) _____
Date _____
Witness _____
Date _____