

Your physician, Dr. \_\_\_\_\_ has requested an x-ray examination, which will involve the injection of contrast material into your body through a blood vessel. The contrast flows through a small needle in you hand or inner arm. The possible minor side effects and complications include but are not exclusive of flushing of the skin, itching, running nose and eyes, sneezing and sweaty palms. More serious side effects are rare but could develop into a condition called Nephrogenic Systemic Fibrosis (NSF), also known as Nephrogenic Fibrosing Dermopathy (NFD).

Symptoms of these conditions include but are not limited to:

- Swelling, hardening, & tightening of the skin
- Reddened or darkened patches on the skin
- Burning or itching of the skin
- Yellow spots on the whites of the eyes
- Stiffness in the joints, problems moving or straightening arms, legs, or feet
- Pain deep in the hip bone or ribs
- Weakness of the muscle

Medications and personnel are here to treat any of these events. Your physician feels that the information from this examination outweighs the small risk of the study. Please answer all the following questions.

1. Have you had previous contrast study, such as kidney or blood vessel study? No      Yes  
If yes, what type of study? \_\_\_\_\_
2. Did you have any problem or difficulty with the injection? No      Yes  
\_\_\_\_\_  
\_\_\_\_\_
3. Do you have nay history of: (Please circle if YES)

Hypertension

Diabetes

Kidney Disease

Heart Disease

4. BUN \_\_\_\_\_ Creatinine \_\_\_\_\_ Date \_\_\_\_\_

FEMALES: Is there a possibility that you may be pregnant? Yes      No  
When was your last menstrual period?      Date: \_\_\_\_\_

The examination has been explained to me including the benefits and alternative examinations. All questions have been answered to my satisfaction. I understand the above and consent to and agree with having this examination.

\_\_\_\_\_  
PATIENT Signature      Date

\_\_\_\_\_  
WITNESS Signature      Date

\_\_\_\_\_  
TRANSLATOR (If Needed)      Date

\_\_\_\_\_  
LEGAL GUARDIAN Signature      Date  
(If patient is a minor (under 18), or unable to give consent.)

I have counseled this patient to the procedure(s), attendant risks and expected results.

\_\_\_\_\_  
PHYSICIAN Signature      Date

\_\_\_\_\_  
Sacred Peaks Health Center  
Name of Medical Facility

**RADIOLOGY  
DEPARTMENT**

Magnetic Resonance  
Imaging (MRI)  
Consent Form for  
Contrast Examination



**Tuba City**

Regional Health Care Corporation

167 North Main Street • P.O. Box 600  
Tuba City, Arizona 86045 • (928) 283-2501

RAD-016 (06/14)

PATIENT INFORMATION