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PERTH AMBOY
DIAGNOSTIC IMAGING

I.V. Contrast Consent for CT Scan

Name: _____ Date: _____

Date of Birth: ___/___/_____ Height: _____ Weight: _____ Sex: _____

I, _____, give my consent for the radiologist to perform a Computed Tomography (CT) study on myself.

I understand this study require intravenous administration of iodinated contrasted media or other required pharmaceuticals. The potential risks and possible consequences associated with the performance of this study have been fully explained to me.

Important Note: Only for patients taking Diabetic, Medication, Glucophage, and Glucovance

It has been noted as precaution that Glucophage/Glucovance be withheld at least 48 hours after I.V. contrast CT scan procedure to avoid lactate acidosis.

Upon completion of the examination the patient is responsible for contacting his or her referring physician as to when to reinstitute medication (Glucophage/Glucovance).

Glucophage/Glucovance should be re-instituted after renal function has been reevaluated and found to be within normal limits.

_____ _____

Patient's Signature Signature of Witness