



...Where Patients Come *FIRST*
(716) 631-2500

TODAY'S DATE: _____

CONTRAST SCREENING AND CONSENT FORM

PATIENT NAME	AGE	WEIGHT	REFERRING DOCTOR
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PLEASE TELL US THE REASON DOCTOR ORDERED THIS TEST?

PLEASE LIST ANY ALLERGIES: DO YOU HAVE A LATEX SENSITIVITY OR ALLERGY?	HAVE YOU EVER HAD IV INJECTED DYE IN THE X-RAY DEPT.? ANY PROBLEMS AFTER RECEIVING DYE?
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- RECENT INJURY YES NO
- CARDIAC PROBLEMS YES NO
- STROKE YES NO
- CANCER YES NO
 - Type and when diagnosed _____
 - chemo YES NO
date of last treatment _____
 - radiation YES NO
date of last treatment _____
- BONE TUMOR YES NO
- SEIZURE DISORDER YES NO
- WEIGHT LOSS YES NO
AMOUNT _____ lbs. TIME FRAME _____

- RESPIRATORY PROBLEMS (Asthma/Emphysema/Bronchitis) YES NO
History of smoking YES NO
- ALCOHOL CONSUMPTION YES NO
how often: _____
- HIGH BLOOD PRESSURE YES NO
- DIABETES YES NO
List diabetic medications: _____
- KIDNEY DISEASE YES NO
 - Pheochromocytoma YES NO
 - Dialysis YES NO
- SICKLE CELL YES NO
- BLADDER/BOWEL PROBLEMS YES NO

PLEASE LIST ALL PREVIOUS SURGERIES AND DATES

- _____
- _____
- _____
- _____
- _____
- _____

PLEASE LIST ALL TESTS DONE IN THE PAST 6 MONTHS AND WHERE THEY WERE DONE

TEST	FACILITY
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I AM PREGNANT I AM NOT PREGNANT / LMP _____
 I understand I will be receiving x-rays and hereby release all radiologists, respective staff and the facility thereof of any and all responsibility for any adverse reaction to myself and/or damage to my unborn fetus in the event I may be pregnant.
 SIGNATURE: _____

MEDICATIONS:

CONTRAST DYE:

I understand that x-ray dye will be injected. The indications for and risks of the procedure were discussed with me. The risks were noted to include, but are not limited to, various types of allergic reactions to the iodinated contrast. Most of these reactions are minor, although they can be severe at times. On rare occasions, inflammation or infection at the intravenous catheter site can occur and other more remote risks or consequences may also arise. I have been advised that if further explanation is desired, I may ask additional questions to the staff to include any supervising radiologists and my referring physician.

Signature of Patient or Legal Guardian

Date

Witness to signature

Date

Witness Name (printed)
