KONA COMMUNITY HOSPITAL

# INTRAVENOUS CONTRAST HISTORY

Your doctor has ordered an x-ray exam to help him/her diagnose and treat your medicalcondition.Thisx-rayrequiresthe injection into your vein. We only use the new safest contrast available, called non-ionic, which is six times safer than the older contrast. Still, this may produce occasional side effects. The physicians and staff here are trained to treat these reactions.

**The types of reactions you *might* experience are:**

- ➔ **Minor reactions such as itching or nausea, which requires no treatment. The chance of a minor reaction is about 1 to 100 cases, or 1%.**
- ➔ **Serious reactions such as difficulty breathing, irregular heartbeat, convulsions, kidney failure or unconscious. The chance of this happening is 1 in 6,000 cases, or 0.017%.**
- ➔ **Death is very rare. This happens in 1 in 100,000 cases, or 0.001%.**

**IF YOU HAVE ANY QUESTIONS ABOUT THE EXAMINATION, PLEASE ASK.**

Do you have any of the following conditions?

| Condition | Yes | No | **Check below any reaction/allergies/diseases you may have had or medications** |
|---|---|---|---|
| Pregnant at this time | | | |
| Allergies to: | | | ☐ Iodine |
| Have had intravenous contrast before | | | ☐ No problem ☐ Had Problem (desribe): |
| Previous contrast reaction | | | ☐ Hives or rash ☐ Severe nausea or vomiting ☐ Difficulty breathing ☐ Rapid heartbeat ☐ Shock ☐ Collapse |
| Heart Disease | | | If yes, describe: |
| Kidney Disease | | | ☐ Kidney failure ☐ Have had dialysis now |
| Diabetes | | | ☐ Taking medication ☐ Metformin ☐ Glucophage ☐ Glucovance ☐ Januvia |
| Myeloma or sickle cell anemia | | | |

☐ **I certify that I have read this document (or have had it read to me in a language I understand). The explanations described were provided to me. I have had an opportunity to ask questions. All my questions have been answered to my satisfaction.**

Signature of Patient or Legal Representative _____ Date _____

Print Name of Legal Representative _____ Relationship to Patient _____

**For Radiology Use Only:**

| | | |
|---|---|---|
| BUN:<br>Creatinine: | Tech:<br>☐ Started IV | No lab results<br>☐ O.K. to inject per physician |
| IV Started: ☐ L ☐ R ☐ ER ☐ IP: | IV/Gauge:<br>☐ 22 ☐ 20 ☐ 18 ☐ Power PICC-line | IV Discontinue (time)<br>AM / PM |
| NOTES: IV contrast used - (350 Omnipaque) (320 Visipaque)<br>NaCl flush: ☐ 10 ml ☐ 50 ml | | ☐ 100 ml ☐ 75 ml ☐ 50 ml _____ other |
| Patient reaction: ☐ None | | |
| Reaction noted (Describe signs and actions taken): | | |
| TECH SIGNATURE | DATE: | TIME: |