



**CONSENT FOR MRI PROCEDURE  
INVOLVING CONTRAST MEDIA**

Patient name \_\_\_\_\_ Date \_\_\_\_\_

Social Security # \_\_\_\_\_ DOB: \_\_\_\_\_

Patient at the time of consent was: Awake \_\_\_ Alert \_\_\_ Sedated \_\_\_  
Mentally Compromised \_\_\_

Procedure: Your doctor has scheduled you for an MRI examination requiring the intravenous injection of Gadodiamide.

Referring Physician \_\_\_\_\_ Attending Physician \_\_\_\_\_

Indications for procedure: \_\_\_\_\_  
GFR \_\_\_\_\_ CREATNINE \_\_\_\_\_

Benefits of the procedure: To give your doctor additional diagnostic information.

Risks: Including but not limited to injury to a nerve, artery, or vein, infection or reaction to the material being injected. Reactions could include: INFECTION, ALLERGIC REACTION, DISFIGURING, SCARING, SEVERE LOSS OF BLOOD, LOSS OR LOSS OF FUNCTION OF ANY LIMB OR ORGAN, PARALYSIS OR PARTIAL PARALYSIS, PARAPLEGIA, QUADRIPLEGIA, BRAIN DAMAGE, CARDIAC OR RESPIRATORY ARREST OR DEATH.

Alternatives: Other alternatives may include U/S, CT, or Nuclear Medicine.

List any allergies to Medication or Foods:

1. \_\_\_\_\_ 2. \_\_\_\_\_
3. \_\_\_\_\_ 4. \_\_\_\_\_

List any surgeries:

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Have you had radiation therapy or chemotherapy? Yes \_\_\_ No \_\_\_

If yes please explain why and when:

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I understand by signing this form that I have been informed to my satisfaction concerning the following aspects of my exam.

- A. A diagnosis of the condition requiring the exam.
- B. The nature and purpose of the procedure.
- C. The risks involving the procedure.
- D. The likelihood of success.
- E. Alternatives to this procedure.

And that such information was provided here in or by direct conversation with responsible physician or other health care providers under the supervision and control of the responsible physician.

I understand that the physician, medical personal and other assistants will rely on statements about the patient, the patient medical history, and other information in determining whether to perform the procedure or the course of treatment for the patient's condition and in recommending the procedure which has been explained.

I understand that no guarantees or assurances have been made to me concerning the results of this procedure.

I realize that during the procedure, the physician/surgeon may become aware of condition which were not apparent before the start of the procedure. I therefore consent to any additional or different operations or procedures the physician/surgeon considers necessary or appropriate to treat cure or diagnose such conditions. I understand that any tissues or parts, which are removed, may be used for approved research or disposed of as seen fit by appropriate authorities.

**By signing this form, I acknowledge that I have read or had this form read and or explained to me, that I fully understand its contents, that I have been given ample opportunity to ask questions and that any questions have been answered satisfactorily. I also have received additional information including but not limited to the materials related to the procedures described herein.**

**I authorize Dr. Reich, Dr. Jones III, Dr Jones IV to administer appropriate medical treatment for complication of contrast injection.**

Authorized signature for this procedure:

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of person authorized to sign \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Date \_\_\_\_\_

Witness to Signature \_\_\_\_\_ Date \_\_\_\_\_