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|---|---|---|
| RAD-ONE M & R SOTOGRANDE | **IV CONTRAST QUESTIONNAIRE** | Local 3 Edificio C<br>Puerto Deportivo<br>Sotogrande<br>Tel: 600 44 33 00 |

| **Please complete the following:** | **Please circle** | |
|---|---|---|
| Have you ever been injected with intravenous contrast | YES | NO |
| Did you suffer any side effects or a reaction? | YES | NO |
| **Do you have a history of:** | | |
| Diabetes and are treated with metformin? | YES | NO |
| Allergies? | YES | NO |
| Thyroid disease? | YES | NO |
| Kidney disease? | YES | NO |
| Multiple myeloma? | YES | NO |
| Phaeochromocytoma? | YES | NO |
| Sickle Cell Disease? | YES | NO |
| **For female patients of childbearing age** | YES | NO |
| Are you breastfeeding? | YES | NO |
| Is there a chance that you may be pregnant? | YES | NO |
| Are you currently on any medications? | YES | NO |

If so, please list:

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……..

……..

I have read the above information and am aware of the risks and benefits of being administered intravenous contrast.
I have been provided with the opportunity to have any questions answered and I therefore give my consent to injection of intravenous contrast.

PATIENT NAME SIGNATURE DATE

STAFF USE ONLY

| | | |
|---|---|---|
| Did the patient understand the information sheet? | YES | NO |
| Did the patient give verbal consent? | YES | NO |

AGENT CONTRAST LABEL TIME DOSE ml/SEC

Scan performed by