

Arthrography Consent Form

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|---|-----------------------------|------------------------------|
| <p>1. Are you currently taking or have you recently taken any medication or drug?
If yes, please list: _____</p> <p>_____</p> | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <p>2. Are you allergic to any medication?
If yes, please list: _____</p> | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <p>3. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination?</p> | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <p>4. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures?
If yes, please describe: _____</p> <p><u>Females Only:</u></p> | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <p>5. Are you taking oral contraceptives or receiving hormonal treatment?</p> | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <p>6. Are you taking any type of fertility medication or having fertility treatments?
If yes, please describe: _____</p> | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| <p>7. Are you currently breastfeeding?</p> | <input type="checkbox"/> No | <input type="checkbox"/> Yes |

Informed Consent: Please wait on signing below until we have explained the procedure and risks.

If you are pregnant or think that you may be pregnant, please inform the facility personnel at once.

You have the right to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risk and hazards involved. This disclosure is not meant to alarm you, but rather to inform you of your procedure so that you may choose to give or withhold your consent for the procedure.

Your physician has requested that we perform an arthrographic examination of your _____

Dr. _____ will be performing this procedure.

The purpose of this procedure is to provide information to aid your physician in diagnosing and treating your complaint. This procedure involves administering a local anesthetic and injecting a contrast medium in the joint through a small needle. There may be a slight burning sensation when the anesthetic agent is injected. This will pass quickly. During injection of the contrast medium, you may feel pressure or pain; this is normal for this procedure. Following this procedure, an MRI will be performed to further evaluate the joint.

Potential Risk: The following complications are possible

Anytime an injection is given there is the potential for pain, bleeding, bruising or swelling at the injection site. Untreated complications could lead to loss of use of the joint. You can expect pain or soreness lasting up to 24 hours after the injection. Additional allergic reactions in response to the contrast agent may include hives, shortness of breath or difficulty swallowing. There have been no reported cases of death following the administration of the MRI contrast agent. It is very important that you inform the technologist if you experience any of the aforementioned conditions.

If you have previously had a reaction to a contrast injection such as hives, severe itching, shortness of breath and/or any significant reaction requiring hospitalization, a history of asthma or other allergic conditions, any history of anemia, kidney disorder, are pregnant or breast feeding you must inform the technologist or personnel prior to the injection.

Patient: Printed Name: _____

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I have been given the opportunity to ask questions about the anesthesia, the procedures used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

Patient Signature/Legal Authorized Person

Date

Physician Signature

Date