



**Information for Administration of Intravenous Contrast Medium**

The investigation you have been referred for may require an injection of x-ray contrast medium. This contrast medium improves the detection of abnormalities in the body and without its use, significant abnormalities may remain undetected.

During injection most patients report a transient feeling of warmth or a metallic taste in the mouth.

However, as with all drugs, side effects and adverse reactions are possible. Minor reactions usually consist of itching and facial swelling. More severe reactions can result in shortness of breath and low blood pressure. It is very rare for reactions to be life threatening, less than one (1) in 100,000. In this Radiology Department, we use the latest contrast media where side effects and adverse reactions are kept to a minimum and our staff are trained to deal with any side effects.

More serious adverse reactions are usually related to an allergy to contrast media.

**To reduce the risk of contrast reactions, please answer the following questions:**

- Have you had an **allergic** reaction to x-ray contrast media? YES / NO
- Do you have **any allergies**? eg, medications, bee stings YES / NO
- Do you have **eczema** or **asthma**? YES / NO
- Do you have **poor kidney function, kidney disease or diabetes**? YES / NO
- Are you on **any diabetic medications**? eg metformin/diabex YES / NO
- Do you take **Interleukin-2** or have you taken it in the past 6 months? YES / NO
- Do you take **Beta Blockers**? (a medication for blood pressure and heart conditions) YES / NO
- Do you have an **overactive or underactive thyroid**? YES / NO
- Do you have a possible or confirmed **thyroid cancer**? YES / NO
- Do you take any **thyroid medications**? YES / NO
- Have you previously received or going to have **radioactive iodine treatment**? YES / NO
- Do you have **Myaesthesia Gravis / Sickle Cell Disease or Pheochromocytoma**? YES / NO

If you have any concerns, please raise them with a staff member prior to your study.

**Patient Acceptance**

I have read and understood the above information. I give my permission to have an x-ray contrast injection as part of my examination.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Or legal guardian

**Medical Officer** authorises contrast injection, the patient is unable to sign / has had a previous allergic reaction.

Medical Officer Name: \_\_\_\_\_ Signature: \_\_\_\_\_

If the following have been in attendance:

Interpreter's Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Chaperone's Name: \_\_\_\_\_ Signature: \_\_\_\_\_

<b>Intravenous Contrast Details – Staff Use Only</b>
Dose/Type:
Expiry:
Batch Number: