CONSENT FOR ADMINISTRATION OF GADOLINIUM BASED MR CONTRAST AGENT

I, (Name of patient) ________________________________, understand that I am being given information about MR IV contrast and the risks, to help me make an informed decision. I will be given an intravenous injection of contrast medium. The agent is a sterile and colorless solution that will enhance certain normal structures, clarify certain abnormalities and assist in obtaining additional information that might have otherwise gone undetected in the area being scanned. The use of this contrast has been approved by the Food and Drug Administration. This contrast agent is felt to be safe under certain conditions.

The following are rare risks associated with the administration of MR contrast agent:

1. Allergic reaction. Large, hive-like swelling in the mouth or throat, confusion, dizziness, headache, difficulty breathing or severe allergic reaction may occur. If any of these symptoms occur, additional medical treatment may be necessary.
2. Contrast infiltration. The movement of the contrast agent outside of the vein into other tissues. Treatment of infiltration generally consists of hot or cold packs and the elevation of the extremity. Infiltration most often resolves over time.
3. Patients who have or had kidney disease that are given Gadolinium contrast may have a small risk of developing a disease called Nephrogenic Systemic Fibrosis (NSF). NSF is often associated with thickening and tightening of the skin and scarring. Scarring may involve other parts of the body including the diaphragm, heart, lungs and muscles. The disease is very rare but is a possibility. Approximately 20 million people are injected with this contrast annually. Only 500 biopsy-proven cases have been identified in a decade (10 years). Information was obtained from Radiology Today, Vol. 9 No.20 on 10/6/2008.

Please answer the following question for your protection:

1. How old are you? _______
2. Do you have any allergies? No Yes
   If yes, please specify ____
3. Have you taken antibiotics within the past two months? No Yes
4. Do you have a history of Sickle Cell disease? No Yes Only the trait
5. Do you have a history or condition of any form of kidney complications? No Yes
   If yes, please specify____
6. Do you have diabetes? _____No _____Yes
   If yes, please specify the type of diabetes ___________________________________
7. If you meet any conditions requiring blood work for your creatinine and BUN levels. Please answer the following questions:
   a. Date of most recent blood work______________
   b. Are you African American? ____No ____Yes
   c. Creatinine level ________ Bun level __________
   d. Calculated GFR for African American? _____ for other race? _____

My signature below acknowledges that I have read and understand the statements on this form. I agree to the administration of _______ cc of MR contrast for my examination.

______________________________	______________________________
Signature of Patient/Guardian	Signature of Technologist
______________________________	______________________________
Printed Name	Date and Time