CAREMOUNT MEDICAL

caremountmedical.com

DEPARTMENT OF RADIOLOGY

☐ Mount Kisco	☐ Carmel	☐ Katonah	☐ Poughkeepsie	☐ Mount Kisco Imaging
90 South Bedford Road Mount Kisco NY 10549-3412	Southeast Executive Park 185 Route 312 Brewster NY 10509-2338	111 Bedford Road Katonah NY 10536-2115	2507 South Road * Route 9 Poughkeepsie NY 12601-5465	34 South Bedford Road Mount Kisco NY 10549-3408
914-242-1395	845-278-3500	914-864-4505	845-471-2287	914-242-3200

INFORMED CONSENT FOR RADIOLOGY PROCEDURE OR INTRAVENOUS CONTRAST

Patient Name:_____ Birthdate: _____NextGen#_____

I hereby request and authorize Dr._____ and / or associates or assistants of his / her choice at CareMount Medical to perform on me or the named patient the following procedures or operations:

- ❑ **Biopsy** _____
- ❑ **Arthrogram** _____
- ❑ **Myelogram** _____
- ❑ **Intravenous X-Ray Contrast containing Iodine**
- ❑ **Intravenous Gadolinium contrast for MRI**
- ❑ **Intravenous Radioactive Isotope for PET / CT**

- The above Physician has fully explained to me the nature of this procedure and expected benefits, risks, and alternatives. I have been given the opportunity to ask questions, and all questions have been answered to my satisfaction.
- I understand that during the course of the procedure, unforeseen emergency conditions may arise that necessitate procedures different from, or in addition to those contemplated. I therefore consent to the performance of additional emergency operations and procedures that the above named Physician or his / her associates or assistants may consider necessary.
- I further consent to the administration of such anesthetics as may be considered necessary. I recognize that there are always risks to life and health associated with anesthetics, and such risks, benefits, and alternatives have been fully explained to me.
- Any tissue surgically removed may be examined and retained by CareMount Medical for medical, scientific, or educational purposes. I consent to disposal of these tissues by CareMount Medical in accordance with customary practice.
- **If x-ray contrast or gadolinium is checked above, I understand that it is being used to make certain tissues more visible on my imaging procedure. I understand that I may have an allergic reaction which may range from mild to severe. This reaction may include skin rash, hives, wheezing, shortness of breath, a warm sensation throughout the body, nausea, or a metallic taste. On rare occasion, the intravenous x-ray contrast may leak into the tissues of the arm causing swelling, redness, or pain. On extremely rare occasion, intravenous x-ray contrast can result in anaphylactic shock or even death.**
- **If I take Glucophage, Glucophage-XR, Glucovance, Metaglip, Avandamet, or metformin in any form, I hereby affirm that I will not take it for 48 hours from this procedure. I understand that I may need substitute diabetes medication, and I may need follow-up kidney function blood tests.**
- I acknowledge that no guarantee or assurance has been made to me concerning the results intended from the procedure.
- I understand the nature of this procedure and expected benefits, risks, and alternatives including no procedure at all. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction.

Patient / Relative / Guardian (circle one): _____

PRINT NAME

_____

SIGNATURE

Witness: _____

PRINT NAME

_____

SIGNATURE

Date: _____