hm hospitales

Authorisation for the administration of intravascular contrast agents

You, the patient, are to undergo a test that requires the intravascular administration (into a vein or artery) of an iodinated contrast agent in order to see your blood vessels and other organs (kidney, pancreas, spleen, etc.). Your doctor believes that this test will provide information that will help us to diagnose your problem.

Although contrast agents that present a very low risk are now available, you should be aware that some risks, such as the following, still exist:

- Minor reactions: nausea, itching, wheals, which do not require any treatment and go away on their own. The probability of suffering these reactions is one out of every 100 patients.
- Serious reactions: Breathing difficulties, palpitations, seizures, loss of consciousness, which require medical treatment. The probability of suffering these reactions is one out of every 6000 patients.
- Death: This is very rare, with a risk of only one out of every 100,000 patients, approximately.
- If you have any doubts or questions, please do not hesitate to consult the Technician or Radiologist.

QUESTIONNAIRE

- ☐ **Paediatrics**
- ☐ **Older than 70 years.**
- ☐ **Kidney failure.**
- ☐ **Heart failure.**
- ☐ **History of heart problems.**
- ☐ **Diabetes.**
- ☐ **Haemoglobinopathy.**
- ☐ **Asthma.**
- ☐ **History of allergy.**
- ☐ **Previous reaction to a contrast agent.**

If you have any questions or would like any clarifications and/or information, please talk to the technician or radiologist responsible for the test before you undergo the test.

Authorisation

In ……………………………………., on …………….   …………………….   2………….

After having being informed of the nature and risks of the procedure proposed by the undersigned physician, I freely and consciously give my CONSENT to said procedure being carried out. I have also been informed that I can withdraw this consent at any time.

Name: .... National ID no.: ....

Patient's signature,

Signature of treating physician
Medical licence no.:

Name of legal representative in case of inability of patient to provide consent due to being either a minor or legally incapacitated or incompetent, stating the nature of the relationship (father, mother, guardian, etc.).

Name: .... National ID no.: ....

Signed by:

In my capacity as ...., I hereby authorise the aforementioned procedure.

Refusal

In ……………………………………., on …………….   …………………….   2………….

After having being informed of the nature and risks of the procedure proposed, I freely and consciously DENY/REVOKE (delete as applicable) MY CONSENT to said procedure being carried out and assume full responsibility for the consequences that may arise as a result of my decision.

Reason:
....
....

Patient's signature,
National ID No.:

Witness' signature,
National ID No.:

Physician's signature,
Medical licence No.:

Name of legal representative in case of inability of patient to provide consent due to being either a minor or legally incapacitated or incompetent, stating the nature of the relationship (father, mother, guardian, etc.).

Name: .... National ID no.: ....

Signed by:

In my capacity as .... I DENY/REVOKE (delete as applicable) my authorisation to carry out the aforementioned procedure.