hm hospitales

Authorisation for intravascular administration

You patient requires a test that requires the intravascular administration (by vein or artery) from a iodinated substance, to be able 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 diagnose the patient's problem.

Even though they have introduced elements will small risks, they still exist and are still there.

- Minor reactions: nausea, itching, wheals that does not require any treatment. The probability that these reactions occur are one in every one hundred patients
- Serious reactions: Choking sensation, palpitations, seizures, loss of consciousness. The probability of these reactions are one out of six thousand patients.
- Death: It is highly uncommon. One in one hundred thousand patients.
- If you have any doubts, do not hesitate to ask, addressing yourself to the technician or radiologist.

QUESTIONNAIRE

- ☐ **Pediatrics**
- ☐ **Above 70 year old**
- ☐ **Renal**
- ☐ **Weak cardiac system**
- ☐ **Coronary Disease History**
- ☐ **Diabetes**
- ☐ **Hemoglobinopathy**
- ☐ **Asthma**
- ☐ **Allergy history**
- ☐ **Previous reaction to a substance**

For any doubt, clarification and/or information, we urge you to come in contact with the technician or radiologist responsible of the test.

I AUTHORIZE

After being informed of the nature and risks of the purpose suggested, I free willingly and consciously give my CONSENT for it to proceed. I am also informed that I can recant this consent whenever I believe it is appropriate.

Name:.. ID:...

Patient's signature, Doctor's signature,

Name of the legal guardian in case the patient is unable to consent, either because the patient is a minor, legal incapability or incompetence, with indication of the relationship with the patient (mother, father, tutor, etc)

Name: õ .... ID:..

Signature:

In the quality of õ .... I authorize the procedure of what was just explained.

Madrid, from Å ... to Å ....to.............................

I DO NOT AUTHORIZE

After being informed of the nature and risk that the procedure contains, free willingly y a consciously DENIAL/REVOCATION (scribble what you will not proceed with) OF CONSENT for your procedure, making myself responsible of the consequences that could come along with my decision.

Reason:

õ ....

....

Patient's signature, Witness' signature, Doctor's Signature,

Name of the legal guardian in case the patient is unable to consent, either because the patient is a minor, legal incapability or incompetence, with indication of the relationship with the patient (mother, father, tutor, etc)

Name: õ .... ID:..

Signature:

In the quality of õ .... I deny/revoque *(scribble what you will not proceed with)* the authorization to perform the process mentioned.

Madrid, from Å ... to Å ....to.............................