

Facility:



PET/CT NAF FDG Consent Form

FORM.POL.002 Effective Date: August 1, 2013

Patient Name: _____ **Today's Date:** _____

This PET/CT examination is done by using a special computer, which allows us to view internal organs, typically not visualized using standard imaging techniques.

ALL PET/CT examinations require the injection of a radioisotope (tracer) into your bloodstream. The use of this tracer helps us to visualize certain organs inside the body, which are not normally seen well, and provides the radiologist with information, which is necessary in evaluating your exam.

This tracer is given through a small needle placed into the vein, usually on the inside of your elbow or on the back of your hand. The tracer is considered quite safe; however any injection carries a risk of harm including injury to a nerve, artery, or vein, or infection or reaction to the material being injected. These reactions are very rare.

Please answer the following questions so that we may evaluate if you are at high risk for adverse effect to the contrast material:

- YES NO 1). Have you ever had an "allergic" like reaction to any contrast material, which required treatment?
- YES NO 2). Do you have allergies or asthma?
- YES NO 3). Do you have a history of heart disease or high blood pressure?
- YES NO 4). Do you have a history of myeloma, sickle cell disease, polycythemia, or pheochromocytoma?
- YES NO 5). Do you have a history of kidney disease or diabetes?
- YES NO 6). Is there any chance that you are pregnant?
- YES NO 7). Are you breast feeding?

Your doctor has ordered this PET/CT exam, to secure more information, which will aid in the diagnosis of your condition. If you have additional questions regarding your exam, please feel free to discuss them with the Technologist or Radiologist prior to your scan.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTANDS THE FOREGOING, AND IS THE PATIENT OR IS DULY AUTHORIZED BY THE PATIENT AS THEIR AGENT TO GIVE THE CONSENT TO HAVE THE DESCRIBED PROCEDURE PERFORMED.

Signature of Patient or Parent/Guardian

Date