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# CONSENT FOR RADIOLOGY PROCEDURE

**PATIENT:** _____ **DATE:** _____

**PATIENT ID:** _____

**PROCEDURE:** _____

| | | |
|---|---|---|
| Do you suffer any allergies? | **YES** | **NO** |

If **YES,** speciffy _____

| | | |
|---|---|---|
| Heart Disease | **YES** | **NO** |
| Asthma | **YES** | **NO** |
| Diabetes | **YES** | **NO** |
| High / Low Blood pressure | **YES** | **NO** |
| Excessive bleeding | **YES** | **NO** |
| Are you on any blood thinning medication e.g. ASPRIN | **YES** | **NO** |
| Dizziness | **YES** | **NO** |

Other: _____

| | | |
|---|---|---|
| Have you previously had a radiological procedure? | **YES** | **NO** |

If **YES,** did you have any problems? Specify: _____

**FEMALE:**

| | | |
|---|---|---|
| Could you be pregnant | **YES** | **NO** |

Last menstrual period **DATE:** _____

**I hereby give consent for a radiological procedure/and or the introduction of contrast media**
**I have been informed of the common risk factors associated with this procedure / contrast media**

**SIGNATURE:** _____ Patient/Relative

**TO BE COMPLETED BY RADIOLOGIST / RADIOLOGIST**

Name of Contrast Media _____

Quantity of Contrast Media given _____

**RADIOGRAPHER/RADIOLOGIST** _____ **DATE:** _____

**Signature**

**Laboratory billing(costs) are billed separately to Parklane Radiology**
**Any Laboratory queries are to be directed to the relative laboratory**