

# CT/CONTRAST CONSENT FORM

The undersigned hereby authorizes and directs Jay A. Kaiser, M.D., Charles P. Ho, M.D., Jana Crain, M.D., and/or their colleagues to conduct a computed tomographic (C.A.T) X-ray scanning examination on me for medical diagnostic purposes.

I also consent to the use of any sedation, anesthesia, contrast media (dye), and antidotes deemed necessary by the attending physician and administered directly by him/her or by someone working under his/her supervision. I acknowledge my awareness of the fact that allergic reactions may result from the use of foregoing medications. I also acknowledge my awareness that the nature of a C.A.T. scanning examination has been explained to me, and that no one has in any way warranted or guaranteed any results of examination.

---

Patients name \_\_\_\_\_ Patients Signature \_\_\_\_\_ Date \_\_\_\_\_

---

Witness \_\_\_\_\_ Date \_\_\_\_\_

IF PATIENT IS A MINOR OR UNABLE TO SIGN, COMPLETE THE FOLLOWING:

Age of minor patient: \_\_\_\_\_ years \_\_\_\_\_ months

Patient is unable to sign because:

---

SIGNING FOR THE PATIENT:

---

Name of signer \_\_\_\_\_

---

Relationship to patient \_\_\_\_\_

---

Signature \_\_\_\_\_

---

Date \_\_\_\_\_

---

Witness \_\_\_\_\_

---

Date \_\_\_\_\_

IN ABSOLUTE RELIANCE UPON THE PATIENT'S CONSENT ABOVE GIVEN, AND WITH PARTICULAR AWARENESS OF THE CONSENT TO THE ADMINISTRATION OF SEDATION, ANESTHESIA, CONTRAST MEDIAL AND ANTIDOTES, I HEREBY AGREE TO CONDUCT A C.A.T. SCANNING OPERATION ON THE ABOVE NAMED PATIENT.

---

Signed \_\_\_\_\_

---

Date \_\_\_\_\_