

Patient Information on Computed Tomography

- Disclosure and Consent Form -

Please read prior to your test and answer the questions on the back.

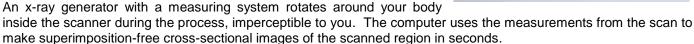
Dear patient!

Technology

Computed tomography (CT) is used to take images of any part of the body free from superpositions. These CT images typically show the type and extent of pathological changes in the brain, internal organs, the spine and the remainder of the skeleton much more accurately than conventional x-ray images.



You will be lying on a special table in the CT room which then moves into the round opening of the scan unit of the CT (see picture) and positioned so you are automatically in the correct position for the scan.



To avoid motion blur in the CT images, it's extremely important to avoid even the slightest movements during the actual scan and follow any breathing instructions.

For scans of the abdominal and pelvic regions, you will be given a contrast agent to drink up to 2 hours before the scan to obtain superior information content. In certain cases, it's necessary to also inject contrast agent into the veins.



The radiation exposure from CT is very low, but typically higher than standard x-rays. Your physician will only order a CT scan if the superior information justifies the radiation exposure. The physician will deliberate if an ultrasound or magnetic resonance imaging (MRI) can be used instead of the CT scan.

When contrast agent is injected, you may briefly notice a warm feeling, which then disappears again.

Although rare, a sensitivity to the contrast agent can cause temporary swelling, itching, sneezing, a skin rash, dizziness, vomiting or similar mild reactions. Serious complications affecting vital functions (heart, circulatory system, breathing, kidneys) and causing permanent damage (e.g. organ failure, palsy) are extremely rare.

In rare cases, the contrast agent can leak into the arm at the injection site when the contrast agent is infused. This will cause painful swelling and in some cases inflammation, which sometimes last for days and require treatment.

If you feel pain and swelling of the arm when the contrast agent is infused, please tell us immediately.

We require some information from you to be able to properly plan the scan and enable exact interpretation of it. Please answer the questions on reverse.





Last Name:	
First Name:	
Date of Birth:	
Telephone Num	ber:

- Disclosure and Consent form -					
Please fill in your a	age, height and your weight	_!			
- Are you sens	sitive to contrast agent?		′es □	No □	
-	rgic?				
•	er had examinations using x-ray contrast agents?	_			
-	a transmittable disease (hepatitis, HIV, etc.)? If so, which?	_			
-	diabetes mellitus?				
-	diabetes medication are you taking? Please specify the name of the medication		_		
- Do you have	or have you had thyroid disease ?	[
If you are taki	king medication for this, please specify the name of your thyroid medication:				
- Do you have	or have you had thyroid cancer ?	[
- If you are reg	gularly taking other medications not listed above, please list these below:				
- Do you have	a kidney disorder?	[
- Creatinine / 6	eGFR: TSH:				
- Our final ques	estion for women of child-bearing age:				
Is there a pos	ssibility you may be pregnant ?	[
The following que	lestions will help us best adapt the procedure to your specific condition	n:			
- Please descri	ribe the reason for this test (e.g. type, location, duration of symptoms):				
•	er had imaging examinations of this specific body part (x-ray, MRI, CT)?				
Where are the	ne images from this examination test?				
- Have you had	d previous surgeries, serious illnesses or do you have chronic condition	s ? If so	, plea	ise	
explain (whicl	ch? when?) below:	[
administered control RNZ archives this records and can be	urther questions, please ask us prior to your scan. If you agree to the planned trast agent if required for your specific scan, please sign below. Is patient information and consent form in compliance with the statutory obligation be accessed at any time during this period.				
I hereby waive my	right to receive a copy of this patient information and consent form.				
Place, Date	Patient's Signature Physician's Signature	 ·е		-	

Date: 03/2020

Physician's Signature
The CT is medically indicated