INFORMED CONSENT FOR DIAGNOSTIC IMAGING WITH CONTRAST

Surname, first name .....

ID | | | | | | | | | | | No. (PESEL)

I hereby express my consent to a diagnostic imaging examination:

– X-RAY ☐ – CT SCAN ☐ - MRI ☐

I declare that:

- I have been informed in an understandable way about the type of examination, indications, contraindications, possible complications connected with the use of contrast media and I **give my informed acceptance to them**.
- The information I have provided regarding my health condition, the course of my treatment to date, and the medications I am taking is factually correct.
- I have been informed of a possible modification of the examination method, if necessary, and I accept it.
- I acknowledge that I have had the opportunity to ask questions about the type of examination, its purpose, expected results, associated risks and potential complications.
- I confirm that I have had sufficient time to make a fully informed decision.

At the same time **I give / I don't give my consent*** to medical procedures to be performed when it will not be possible to obtain my consent due to a limitation of my ability to give informed consent, and these changes are deemed by the UCK medical team to be urgent and necessary for the continuation of the treatment.

…… ……

(date and legible signature of the patient of the doctor) **(stamp and signature**

As the legal guardian of the child (parent)/ of a partially incapacitated person / incapacitated person **I give / I don't give*** my consent to the above examination of my child / partially incapacitated person / incapacitated person. At the same time I confirm that I have been informed that the above-mentioned examination of my minor child who is over 16 years of age / a partially incapacitated person / an incapacitated person who is able to express their opinion on the matter with understanding also requires the patient's own consent

……
(date and legible signature of the patient's legal representative or an authorised person)

WEIGHT	**HEIGHT**	**CREATININE**	**GFR**	**CONTRAST/DOSE**
……kg	……cm	……mg/dl	……ml/min	

The radiologist's recommendations with regard to the examination:

Time of administration
Nurse's signature

Doctor's signature

Statement

After intravenous administration of contrast: ..... no driving or operating
name
precision equipment are allowed for the duration of 1 hour from the last administration. Drink plenty of fluids – about 2 litres per day. Information received

……

(date and legible signature of the patient)