HOSPITAL FOR SPECIAL SURGERY

535 East 70th Street
New York, NY 10021

CONSENT FOR ADMINISTRATION OF CONTRAST AGENT FOR RADIOLOGIC/ IMAGING EXAMINATION

DEPARTMENT OF RADIOLOGY AND IMAGING

I hereby give consent to _____ and Hospital for Special Surgery and its Radiology staff (including residents and fellows) to perform the following procedure: _____ _____ upon _____

(Description of Procedure) *(Name of Patient)*

The practitioner named above has explained to me and discussed with me the nature, intended purpose, anticipated benefits, material risks, and possible complications of the above procedure, the alternatives if such procedure is not performed, and the probable consequences if such procedure or alternatives are not performed. I understand that the risks and possible complications of this procedure include: nausea; vomiting; inflammation. pain, and, in rare occasions, swelling in the vein or the surrounding area where the contrast agent is injected; and allergic and sensitivity reactions ranging from hives to respiratory distress to, in very rare cases, death.

I give this consent with full knowledge and understanding that medicine is not an exact science, that there is the possibility that the procedure may not have the benefits or results intended, and that there are always risks and dangers to life and health associated generally with medical procedures which can cause adverse consequences not ordinarily anticipated in advance.

I understand that during the course of the procedure, unforeseen conditions may be revealed or encountered, and that procedures in addition to or different from those described above may be necessary or desirable to address those conditions. I consent to the above named practitioner or other member of the Hospital's Radiology staff or designee performing on me/the patient such additional procedures as they deem necessary or desirable.

I understand that some important tasks may be performed by practitioners other than the practitioner named above, and I consent to their doing so. The specific tasks will be determined based on the practitioner's skill set, scope of practice under New York law, and privileges granted by the Hospital, and will be performed under the supervision of the practitioner named above and/or another qualified member of the Hospital's Radiology staff. Post-graduate physicians (residents and fellows) and qualified medical practitioners who are not physicians (physician assistants, nurse practitioners, and radiologic technologists) may be involved in the administration of the contrast agent or the radiologic/imaging examination.

I consent to the photographing, videotaping, televising, or other observation of the procedure as the Hospital or the above named practitioner or another member of the Hospital's Radiology staff may deem useful or appropriate for scientific and/or educational purposes, with the understanding that my/patient's identity will remain confidential.

I consent to the presence during the procedure of a visitor(s), which may include a visiting physician and/or a vendor representative whose presence has been requested by the above named practitioner or another member of the Hospital's Radiology staff. I understand that the visitor(s) will at all times be under the supervision and direction of an attending radiologist and other Hospital personnel, and subject to all relevant Hospital policies and procedures.

I confirm that I have read and fully understand this document, that I have been given the opportunity to ask questions about the procedure and have had my questions answered satisfactorily, and that I am eligible to give this consent.

Signature of Patient/Parent/Guardian/Health Care Agent _____ **Date** _____ **Time** _____

Relationship to Patient _____

Witness Certification: I certify that I have witnessed the person whose signature appears above signing this Consent for _____ Administration of Contrast Agent for Radiologic/Imaging Examination.

Signature of Witness _____ **Date** _____ **Time** _____

Practitioner Certification(s): I certify that I have explained to and discussed with the person whose signature appears above the nature, intended purpose, anticipated benefits, material risks, and possible complications of the procedure specified above, the alternatives, and the probable consequences if the above procedure or alternatives are not performed.

Signature of Practitioner _____ **Date** _____

(Physician, Physician Assistant, Nurse Practitioner)