

DOB _____

THIS PAGE IS TO BE FILLED OUT WHEN YOU ARRIVE FOR YOUR EXAM.

I understand the procedure and give permission for the intravenous injection of contrast material.

Patient/Guardian Signature

Date: _____

Witness Signature

Date: _____

TO BE COMPLETED BY DEPARTMENTAL STAFF

Exam: _____

Dx: _____

Contrast Type: _____

Amount: _____

NDC # _____

Injection Site Information:

Angiocath

Butterfly

Injection Site

_____ 18ga.

_____ 21ga.

_____ Wrist

Rt.

Lt.

_____ 20ga.

_____ 23ga.

_____ Antecubital

Rt.

Lt.

_____ 22ga.

_____ 25ga.

_____ Hand

Rt.

Lt.

_____ Forearm

Rt.

Lt.

Technologist: _____

Date: _____

Radiologist: _____

Date: _____