

# 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.



### Process

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.

An x-ray generator with a measuring system rotates around your body inside the scanner during the process, imperceptible to you. The computer uses the measurements from the scan to make superimposition-free cross-sectional images of the scanned region in seconds.

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.

### Which side effects and complications may occur?

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 Number:	_____

**- Disclosure and Consent form -**

Please fill in your age \_\_\_\_\_, height \_\_\_\_\_ and your weight \_\_\_\_\_!

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| - Are you <b>sensitive to contrast agent</b> ? .....                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| - Are you <b>allergic</b> ? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| - Have you ever had examinations using x-ray contrast agents? .....                     | <input type="checkbox"/> | <input type="checkbox"/> |
| - Do you have a <b>transmittable disease</b> (hepatitis, HIV, etc.)? If so, which?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| - Do you have <b>diabetes mellitus</b> ? .....  | <input type="checkbox"/> | <input type="checkbox"/> |

If so, which diabetes medication are you taking? Please specify the name of the medication:

\_\_\_\_\_  Yes  No

- Do you have or have you had **thyroid disease**? .....

\_\_\_\_\_  Yes  No

If you are taking medication for this, please specify the name of your thyroid medication:

\_\_\_\_\_  Yes  No

- Do you have or have you had **thyroid cancer**? .....

\_\_\_\_\_  Yes  No

**The following questions will help us best adapt the procedure to your specific condition:**

- Please describe the reason for this test (e.g. type, location, duration of symptoms):

\_\_\_\_\_

- Have you ever had imaging examinations of this specific body part (x-ray, MRI, CT)?.....  Yes  No

If so, where was the examination performed? \_\_\_\_\_

Where are the images from this examination test? \_\_\_\_\_

- Have you had **previous surgeries, serious illnesses** or do you have **chronic conditions**? If so, please explain (which? when?) below:  Yes  No

\_\_\_\_\_

\_\_\_\_\_

If you have any further questions, please ask us prior to your scan. If you agree to the planned CT and to being administered contrast agent if required for your specific scan, please sign below.

RNZ archives this patient information and consent form in compliance with the statutory obligation to preserve records and can be accessed at any time during this period. Yes

I hereby waive my right to receive a copy of this patient information and consent form.

\_\_\_\_\_  
Place, Date

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Physician's Signature  
The CT is medically indicated