BLUE STAR IMAGING
Boerne

CONSENT FOR ARTHROGRAMS/STEROID INJECTIONS

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ ☐ Male ☐ Female

What symptoms are you experiencing? _____

Have you had surgery to the area we are injecting? _____

Are you allergic to any medication? _____

If yes, please list: _____

Do you have a history of allergic reactions to local anesthetic and/or a contrast medium (dye) used for an MRI, CT or X-Ray examination? _____

FEMALE PATIENTS ONLY

☐ **Yes** ☐ **No** Is there a chance that you are pregnant?
☐ **Yes** ☐ **No** Are you currently pregnant?
☐ **Yes** ☐ **No** Have you had a hysterectomy or tubal ligation?
☐ **Yes** ☐ **No** Are you currently nursing?

FORM OF BIRTH CONTROL

☐ Abstinence
☐ Birth Control Pills/Patch
☐ Diaphragm
☐ Other
☐ Condom
☐ IUD
☐ Menopause
☐ None

What is the date of your last menstrual cycle? _____ To _____

I have informed the technologist that I am NOT pregnant at this time.

Signature: _____ Date: _____

Your doctor has requested that you have an injection of contrast material (iodine based and/or MR contrast) or steroid. For an arthrogram, your physician feels that your scan may produce the best possible diagnosis using this method.

Local anesthesia will be administered under the skin. A small needle will be placed into your joint using sterile technique. Contrast and saline will be injected into your joint under image guidance. You will feel a pressure-like discomfort in your joint for 24-48 hours.

The following complications are possible:

Anytime an injection is given there is the potential for pain, bleeding, bruising or swelling at the injection site. Untreated complications could lead to loss of use of the joint. You can expect pain or soreness lasting up to 24 hours after the injection. Additional allergic reactions in response to the contrast agent may include hives, shortness of breath, or difficulty swallowing. There have been rare instances of death following the administration of the contrast agent. It is very important that you inform the technologist if you experience any of the above conditions.

I certify that this form has been fully explained to me, that I have read it or have had it read to me, and that I understand its contents. I have been given the opportunity to ask questions about the anesthesia, the procedures used, and the risks and hazards involved, and I believe that I have sufficient information to give this informed consent.

I attest that the information I have provided for myself or family member is correct to the best of my knowledge and I hereby give consent for my procedure:

Patient/Parent or legal guardian signature: _____ Date: _____

Technologist Signature: _____ Date: _____

Radiologist Signature: _____ Date: _____

OFFICE USE ONLY

Fluoroscopy Time: _____ DAP: _____ (uGy*^{m2}) Kerma: _____ (mGy)

Lidocaine:	Amount:	_____	Lot:	_____	Exp:	_____
Omnipaque:	Amount:	_____	Lot:	_____	Exp:	_____
Clariscan:	Amount:	_____	Lot:	_____	Exp:	_____
Steroid:	Amount:	_____	Lot:	_____	Exp:	_____