Patient Name:
Date of Birth:
Medical Record #:
Referring Physician:

ARTHROGRAM CONSENT FORM

Allergy to Iodine or Betadine?	☐YES ☐NO
Allergy to any medications?	☐YES ☐NO
Allergy to shellfish?	☐YES ☐NO
Allergy to adhesive tape?	☐YES ☐NO
Is there a possibility that you might be pregnant?	☐YES ☐NO
Are you currently taking any blood thinner (including aspirin)?	☐YES ☐NO
If yes to the above question, when did you stop taking them prior to this procedure?	_____ days
Any previous surgeries to the area of interest?	☐YES ☐NO

If yes to the above question, please indicate the surgery and the date of the surgery.

_____

How was the area of interest injured? _____

_____

1. I hereby grant authorization for the treatment and procedures considered necessary. Such treatment and procedures will be performed by the physician specified in paragraph (2) below and the technologists of Neuroskeletal Imaging.
2. I authorize and direct _____ and designated assistants to perform the arthrogram of the _____ and, if during the course of this procedure any unforeseen condition arises which calls for procedures in addition to or different from those now contemplated, I further request and authorize him to do whatever he deems medically necessary under the circumstances.
3. I understand the inherent risks of this procedure are very low, but potentially include an allergic reaction, mild inflammatory or minor bleeding. These complications are easily treated and rarely progress to serious complications.
4. I fully understand the purpose and risks of the above procedure.
5. This form has been fully explained to me and I certify that I understand its contents. I certify that all of my questions were answered in full.

Signature _____ **Date Signed:** _____

Preparing Technologist's Signature _____

Assisting Technologist's Signature _____

Radiologist's Signature _____