

**Taipei Veterans General Hospital**  
**Instruction and Consent form for Computed Tomography (CT)**  
**Examination**

Ward/Bed#: \_\_\_\_\_ / \_\_\_\_\_ Dpt./Dv. \_\_\_\_\_  
Medical Record No.: \_\_\_\_\_   
Name of Patient: \_\_\_\_\_ Sex: M F  
Patient's Date of Birth: \_\_\_\_ Year \_\_\_\_ Month \_\_\_\_ Day

**Instruction form for Computed Tomography (CT) Examination**

**I. The purpose of suggested exam:**

To better understand the current conditions of your internal organs.

**II. Method of examining:**

Administrate iodinated contrast media through an intravenous injection, and then perform an imaging examination by computed tomography.

**III. Risks of the examination:**

1. When contrast media is used, whole-body flush may occur (incidence rate: about <1%).
2. Few people may experience light allergic reactions (incidence rate: about <1%), including: vomiting, dizziness, sneezing or stuffy noses; however, these often disappear after a short period of time.
3. Anyone who is anaphylactic may experience serious reactions such as papules, urticaria, chills, chest tightness or breathing difficulties (incidence rate: 1/1,000,000).
4. Anyone who is anaphylactic may experience rare throat edema, asthma or abnormally low blood pressure, heart failure, shock and sudden death (death rate: approximately 1/40,000-1/100,000).
5. Contrast media will cause renal toxicity with 48hrs of usage; creatinine will increase by 25% compared to the baseline values or the absolute value increase of at least 0.5mg/mL. Symptoms will persist for 2-5 days. Incident rate is <2% of the patients in general, but for high- risk group of patients may be increase to >50 %. The contrast media is the third most common cause of renal failure (about 11% ).

**IV. Possible complications of the examination and procedures for alleviation:**

Anyone with the following conditions is more likely to have a serious reaction from the contrast media. In order to protect the safety of the person being examined, please read the following carefully; if the following circumstances occur, please notify the staff. Depending on the situation, the physician will consider other possible alternative examinations.

1. Adverse reactions caused by the administration of iodinated contrast media
2. Allergic asthma
3. Allergies to other food or medication
4. Hyperthyroid or diabetes
5. Renal disease or known renal dysfunction
6. Multiple bone marrow disease or pheochromocytoma
7. Major cardiac or lung disease

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**V. Possible transient or permanent symptoms**

1. Flush sensation;
2. Potential allergic reaction (described in section III. 2-5);
3. Deteriorate renal function.

**VI. Alternative methods**

The CT scan may be performed without the administration of the contrast media; however, in most cases the accuracy of this examination is lower which may affect the diagnosis.

**VII. Things you should know before, during and after examinations**

1. Radiologist will determine if the contrast is needed based on your condition.
2. Please wear clothes without metal buttons or zippers.
3. You may continue with your medication for heart disease or hypertension, except for Diabetes Mellitus.
4. If you cannot make it for the appointment, please call the following number to inform us, otherwise it will be regarded as cancelled (02-28752121 ext. 3302, CT room).
5. Please drink at least 1,500ml of water after the examination to accelerate the excretion of the contrast.

**VIII. Health insurance benefits:**

This examination is covered by the National Health Insurance if you meet the policies. If your doctor orders image reconstruction, we will inform you the additional processing fee not covered. Please call 02-28752121 ext. 3302, CT room if there are further queries.

※ This instruction provides the details of the purpose, method and potential complication of the arranged exam. Please read carefully and sign the consent form after the medical staff's explanation.

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Ward/Bed#: _____ / _____ Dpt./Dv. _____
Medical Record No.: _____ <input type="checkbox"/>
Name of Patient: _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Patient's Date of Birth: _____ Year _____ Month _____ Day

**Consent form for Computed Tomography (CT) Examination**

**I. Scheduled Examination (If the medical terms are not clear, please note with the brief explanations)**

1. Ailment:
2. Suggested examination: Computer Tomography (CT)
3. Reason for Suggested Exam:

**II. Declaration**

1. I have explained to the patient the information, related to this examination to his/her understanding, and to the best of my ability, especially the following:

- The reasons for the examination, its method and scope, risk and success rate.
- Possible complications of the examination and the procedures for all eviation.
- In the event there is other information related to the treatment, I have relayed it to the patient for their reference.
- Possible transient or permanent symptoms that may arise from examination.
- If available I have delivered other information about the examination.

2. Under the following circumstances, the administration of contrast media will not be considered and alternative examinations will be suggested according to the circumstances:

- Adverse reactions caused by the administration of Iodine Containing Contrast Media.
- Allergic Asthma
- Allergies to other food or medication
- Hyperthyroidism
- Renal disease or known renal dysfunction
- Multiple bone marrow disease or pheochromocytoma
- Major cardiac or lung disease

3. I have allowed sufficient time for the patient to ask the following questions concerning this examination, and have given the necessary answers:

- (1) \_\_\_\_\_
- (2) \_\_\_\_\_

Doctor's signature: \_\_\_\_\_ Date: Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_ Time: Hour \_\_\_\_\_ Minute \_\_\_\_\_

**III. Patient's declaration**

1. The physician has explained to me, and I fully understand the relevant information on the necessity, procedure, risk and rate of success for this examination.

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2. The doctor has explained to me, and I understand the possible outcomes of undergoing the examination, the risks of not undergoing it, and other alternative methods of examination. I also have responded to the following questions (Yes-V, No-X):

- Adverse reactions caused by administration of Iodine containing contrast media
- Allergic asthma
- Allergic to other food or medication
- Hyperthyroidism
- Renal diseases or known renal dysfunction
- Multiple bone marrow disease or pheochromocytoma
- Major cardiac or lung disease

3. I understand that this examination maybe the most appropriate option right now.

Based on the above declaration, I agree to undergo this examination. In the event an administration of contrast media is needed, I agree do not agree to receive contrast media.

4. I understand that if an organ or tissue needs to be removed during the examination, the hospital may keep them for a period of time for examination purposes and will handle them carefully and in compliance with the law.

5. I understand that this examination might be the most appropriate option currently, but it does not guarantee the improvement of the disease course or outcome.

6. I am able to ask the doctor questions and express concerns about my condition, the process of the examination, and the method of the examination. I have received explanations from the doctor.

**Based on the above statement, I  agree  disagree to undergo this examination**

Name of person completing the form: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date: Day \_\_\_\_ Month \_\_\_\_ Year \_\_\_\_ Time: Hour \_\_\_\_ Minute \_\_\_\_

Witness Name: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Date: Day \_\_\_\_ Month \_\_\_\_ Year \_\_\_\_ Time: Hour \_\_\_\_ Minute \_\_\_\_

**Note:**

1. When the patient is a minor (under 18 years old) or unable to give consent for other reasons, the signature can be provided by the legal representative, spouse, relative or other relevant person.
2. If the person completing the form is not the patient him/herself, please fill in your relationship with the patient.
3. If there is no witness present, leave it blank.