WINDHAVEN
MEDICAL IMAGING

## DISCLOSURE AND CONSENT FOR DIAGNOSTIC PROCEDURES

I understand that the following diagnostic exam has been ordered for me by my referring physician.
I voluntarily consent and aurthorize Windhaven Medical Imaging to complete the ordered exam within the standards set by the supervising Radiologist.

Although risks associated with an IV are very small, it is in your best interest to be fully informed of any possible . associated risks.

1. Infection of IV site
2. Allergic Reaction
3. Hematoma (bruising)
4. Thrombosis (Blood Clot)
5. Infiltration
6. Localized Pain/Tenderness

**Patient Name** _____ **Legal Guardian (If under 18 years)** _____

**Patient Signature** _____ **Witness** _____

**Date:** _____ **Exam:** _____

***Below for Office use only***

**Physician Instructions:**

1. If patient is having contrast, place injection port.
2. Flush pre- and post-scan with 2 cc 0.9% Sodium Chloride
3. D/C port post scanning
   S.O. Dr. Bundy and/or Associates

| Time: | Actions: | Initials: |
|---|---|---|
| _____ | Scheduled Appointment time | _____ |
| _____ | Chart up and MA called | _____ |
| _____ | To dressing area | _____ |
| _____ | Started drinking PO contrast Gastroview or Scan C | _____ |
| _____ | To IV room & saline lock placed, location: 18 20 22 24 gauge, ____ X ____ attempt(s) | _____ |
| _____ | To MRI or CT for procedure | _____ |
| _____ | Saline Lock removed post scan by: | _____ |

Notes:

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