



Beth Israel Deaconess Medical Center

Boston, MA 02215

CONSENT FOR ADMINISTRATION OF GADOLINIUM CONTRAST IN RENAL DYSFUNCTION MRI Department

PATIENT'S NAME _____

MED. REC. # _____

DOB _____

Patient Identification

My radiology provider, _____, has discussed gadolinium contrast with me and its use for identifying specific abnormalities on MRI (magnetic resonance imaging). My radiology provider has also explained to me that blood tests indicate I may be at risk for developing a disease called Nephrogenic Systemic Fibrosis (NSF) if I receive gadolinium contrast for my MRI.

Benefits and Alternatives to Treatment: My radiology provider has spoken with me about the information that is expected from this MRI, but made no guarantees or promises about the results of the MRI. My radiology provider has also explained that an MRI with gadolinium contrast is the best way to evaluate my symptoms or condition of _____, and that there are no alternative tests that would provide information of comparable quality or value.

Risks: Gadolinium contrast has been linked to the development of a disease called NSF (Nephrogenic Systemic Fibrosis). NSF results in hardening and thickening of the skin, and possibly internal organs, which can lead to pain, joint stiffness, inability to walk, and possibly death.

NSF has only occurred in patients whose kidneys do not work properly. Most cases of NSF have occurred in patients with severe or end-stage kidney disease, defined as a glomerular filtration rate less than 30 mL/min/1.73 m². Your most recent glomerular filtration rate was estimated at _____ mL/min/1.73 m² on ____/____/____.

NSF is rare. Fewer than 500 cases have been identified worldwide since the first known case in 1997. Based on early data, the American College of Radiology estimates the chances of developing NSF at 3-5% after gadolinium exposure for patients with severe or end-stage kidney disease.

I understand that:

- I should seek medical care if I experience skin tightening or pain or stiffness in my arms or legs.
• Other risks may arise and additional complications may occur. I also understand that other unforeseen conditions may be revealed that require additional procedures.
• Ongoing discussions(s) about my current status and recommended treatment steps will be part of my care.
• I retain the right to refuse any specific treatment.
• Under the supervision of my radiology provider, other clinicians, including resident doctors, clinical students and staff may be involved in or observe my care.
• I may receive a copy of this consent upon request.

I have had the chance to discuss this consent form with the radiology provider, ask questions and have my questions answered. In signing this form, I understand that I am consenting to the administration of gadolinium contrast.

X _____ or X _____ and _____ / ____/____
Patient's Signature Person authorized to sign for patient Relationship to patient Date

I have explained the statements above to the patient or authorized representative of the patient, and answered all questions.

X _____ M.D./N.P./P.A. _____ M.D./N.P./P.A. _____ / ____/____
Provider's Signature Print Name Date