FAKULTNÍ NEMOCNICE OLOMOUC
Zdravotníků 248/7, 779 00 Olomouc
Tel. 588 441 111, E-mail: info@fnol.cz
ID: 00098892

DEPARTMENT OF NUCLEAR MEDICINE

Patient's/legal representative's informed consent to scintigraphy examination

Patient – name and surname:	Birth registration number (insurance number):
Date of birth: (if no birth certificate number exists)	Health insurance company code:
Patient's permanent address: (or other address)	
Name of legal representative (guardian):	Birth Registration No.

Name of procedure

Scintigraphy examination of an organ or search for a pathological focal lesion

Purpose of the procedure

This examination will provide information about the performance of the organs examined or about the site of existing pathological processes. This examination may include whole-body imaging and/or SPECT imaging in sections in various planes.

Nature of the procedure

Scintigraphy is a diagnostic examination method which includes administration of a substance labelled with a radioactive isotope having a short elimination half-life. This substance is usually administered by injection, although administration through a catheter or by swallowing or inhalation is also possible. The examination itself uses a scintillation camera, which monitors the distribution of the radiopharmaceutical in the body (how the substance is captured by the focal lesion/organ and subsequently eliminated from the body, etc.). The patient must be in a recumbent position, at rest during the examination.

Expected benefit from the procedure

This examination will provide information about the performance of the organs and/or about the site of any pathological processes. This is important for the diagnosis and choice of further treatment.

Alternatives to the procedure

There are no alternative options providing identical information about the function of the organs and/or site of a pathological process. Sonography, CT and magnetic resonance imaging provide better information particularly about the structure of the organs, scintigraphy provides information about the function distribution. The specific examination type is indicated by the physician based on the information required.

Potential risks of the procedure

Radiation stress associated with this examination is similar to that in the majority of radiodiagnostic procedures.

Consequences of the procedure

This procedure is associated with no typical adverse effects.

Information on discharge after administration of the radiopharmaceutical

You need not limit your contact with your family due to the radiation stress (it is advisable, though, to wait for a few hours before you get in contact with children and/or pregnant women). If the patient is incontinent, vomiting, etc., the dirty diapers or other materials must be stored in a plastic bag outside the residential areas (e.g. in a cellar or garage) for 48 hours and then either disposed of or washed.

Consent:

Note: Circle your answer		
Are you pregnant?	YES	NO
Are you breastfeeding?	YES	NO
I have been clearly informed about the alternatives that are available to me at the University Hospital Olomouc.	YES	NO

I have been informed about the potential limitations to my usual way of living and to my working ability after the medical procedure and about potential changes in my medical fitness in the event of potential or expected change in my health.	YES	NO
I have been informed about the treatment regimen and appropriate preventive measures as well as about the follow-up medical procedures.	YES	NO
I have understood all of the explanations and information that were provided and explained to me by a healthcare professional. I had the opportunity to ask additional questions, which were answered to me to my satisfaction.	YES	NO

After the aforementioned information, I declare that:		
- I agree to the medical care and procedure proposed. I also agree to any additional interventions that may be immediately required to save my life or health in the event of any unexpected complications	YES	NO
- I did not withhold any facts about my medical condition that are known to me and which might have an adverse impact on my treatment or endanger people around me, particularly by transmission of an infectious disease	YES	NO
- I give my consent to the collection of my biological material (blood, urine…) for the appropriate analyses, particularly in order to rule out any infectious disease.	YES	NO
- I agree to the presence of students and/or interns during medical services provision	YES	NO
- I agree to it that students and interns may view my medical documentation, but only to the necessary extent and based on permission granted to them by an authorised healthcare professional.	YES	NO

Date	Time	**Signature of the patient** or legal representative (guardian)

Name and surname of the authorised healthcare professional who informed the patient about the preparatory activities and the procedure itself	**Signature** of the authorised healthcare professional who informed the patient about the preparatory activities and the procedure itself

Name and surname of the physician who informed the patient about the indications and contraindications of the examination	**Signature** of the physician who informed the patient about the indications and contraindications of the examination	Date	Time

If the patient cannot sign himself/herself, provide the reasons for this:			
Describe how the patient expressed his/her will:			
Name and surname of the healthcare professional/a witness who was present:	**Signature of the healthcare professional/a witness who was present:**	**Date**	**Time**