NAME AND SURNAME OF PATIENT:____

DATE OF BIRTH:________________________________

PATIENT'S BARCODE TAG
XXXX XXX XX XXX X XXXXXX

ANAMNESTIC QUESTIONNAIRE

The patient is suffering from		
Waldenstrom's paraproteinemia	☐ yes	☐ no
Severe hepatic failure	☐ yes	☐ no
Severe or moderate renal insufficiency	☐ yes	☐ no
Multiple myeloma	☐ yes	☐ no
Severe myocardia or cardio-circulatory failure	☐ yes	☐ no
Hyperthryreosis	☐ yes	☐ no
Hyper-sensitivity to iodine	☐ yes	☐ no
Presence of allergic reactions in medical history		
Previous allergic reaction to the contrast medium	☐ yes	☐ no
Previous anaphylactic reactions	☐ yes	☐ no
Bronchial asthma	☐ yes	☐ no
Allergic contact dermatitis	☐ yes	☐ no
Reaction to beta-lactam antibiotics	☐ yes	☐ no
Food allergies	☐ yes	☐ no
Other atopic reactions	☐ yes	☐ no
Pregnancy	☐ yes	☐ no
Report any ongoing treatment with the following medications		
Beta blockers	☐ yes	☐ no
Biguanide drugs	☐ yes	☐ no
Interleukin 2	☐ yes	☐ no

PRINT ON BOTH SIDES

In the presence of contraindications to the use of a contrast medium, contact Radiology to set the date of the examination.

THE REQUESTING DOCTOR

I hereby state I have informed and delivered the information notes to the patient, that we have completed the questionnaire together. Therefore, I hereby request this examination with contrast medium.

Date……………… Signature and stamp of the requesting doctor ………………………………………..

THE PATIENT

Deems he has been sufficiently informed and to have received specific written information and declares he has contributed to the completion of the questionnaire providing accurate and complete information.

Date………………Signature of patient ………………………………………………………….

PATIENT'S BARCODE TAG
XXXX XXX XX XXX X XXXXXX

I, the undersigned______________________ born in ________________ on ______________________

Declare that I have been fully informed, through the interview with Dr/s________________________________

About ____(write disease or suspected diagnosis) and:

I agree I do not agree

to undergo ____

(report diagnostic or therapeutic procedure - and specify the location/side of the operation) and a possible

______________________________*(write consent to other operations connected to the main one).*

In particular I have read and understood the information contained in the **Information Note** ___________________________*(specify code)* that was given to me and explained clearly in all its points:

- Description of the suggested treatment
- Potential benefits and disadvantages
- Possible risks and complications
- Possible alternatives
- Possible outcomes of non-treatment
- Possible recovery problems

PRINT ON BOTH SIDES

Any comments ____

I therefore freely and explicitly give my consent to the realization of the proposed treatment, aware that I can withdraw my give consent at any moment.

Date, .../......../.........

Signature of patient* **Signature of parent/s or of a person who exercises parential responsibility ****

____

Stamp and legible signature of the Physician_________________________________

Consent achieved with the aid of an interpreter / cultural mediator: YES NO
Signature of the interpreter / cultural mediator ____

Having understood what has been explained, I freely and consciously decide **NOT TO AGREE** to be subjected to the treatment described above, aware of the consequences of that decision.

Signature of the patient Signature of Physician

* In the case of a legally incapacitated patient the signature must be made by the guardian; in the case of an incapacitated patient, the incapacitated person must sign as his will prevails over that of the curator.
** He/she expresses the will in question also for the other parent (excepting explicit dissent by one of the parents, in which case the Tutelary Judge will have to be involved). In cases of exclusive custody, exercising parental responsibility lies with the person and / or parent to whom the child is assigned.