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DEPARTMENT OF NUCLEAR MEDICINE

Patient's/legal representative's informed consent with radioiodine accumulation test

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 the procedure

Radioiodine accumulation test

Purpose of the procedure

The examination provides information about the rate of iodine uptake in the thyroid gland and the rate of its release from the thyroid gland.

Nature of the procedure

During this diagnostic test, the patient drinks a very small amount of a radioactive isotope of iodine. Regular measurements with a special probe over the thyroid gland monitor changes in the amount of radioiodine in the thyroid gland. It is a multi-day measurement.
In the 2-3 months prior to the examination, the patient should not come into contact with iodine (drugs containing iodine, iodine disinfectants, X-ray contrast agents).

Expected benefit from the procedure

Information on the intensity of iodine uptake in the thyroid gland and the rate of iodine release from the thyroid gland is important for refining the diagnosis and necessary for determining the dose of radioiodine required for successful thyroid therapy.

Alternatives to the procedure

None.

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 existing alternatives 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 and these were answered to my satisfaction.	YES	NO

After obtaining 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 the presence of 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 his/her 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 procedure	**Signature** of the physician who informed the patient about the indications and contraindications of the procedure	Date	Time

If the patient is unable to sign himself/herself, explain the reasons of 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**