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Your Image Means the World to Us!

MRI PATIENT HISTORY AND CONSENT

PATIENT DEMOGRAPHICS

Patient Name: _____ Medical Record #: _____
Date of Exam: _____ Referring Dr.: _____
Date of Birth: _____ Age: _____ Height: _____ Weight: _____ ☐ Male ☐ Female

WARNING: THE MRI SYSTEM MAGNET IS ALWAYS ON

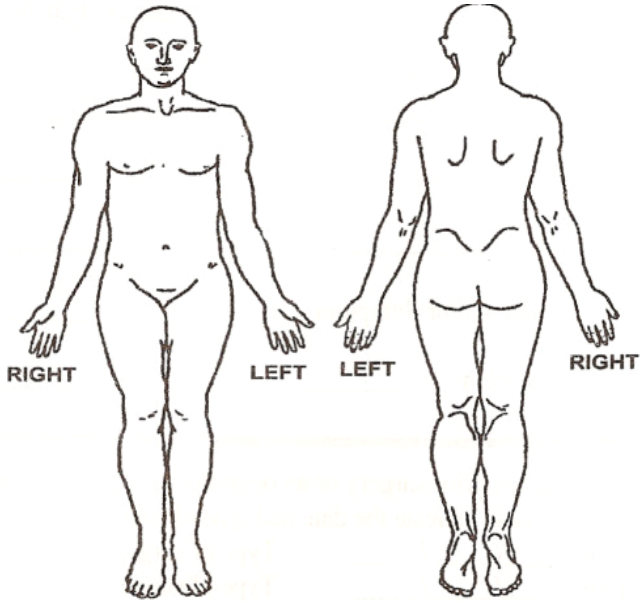
Certain implants, devices or objects may be hazardous and/or may interfere with your MRI procedure.
Do not enter the MRI exam room if you have questions or concern regarding an implant, device or object.
Consult the MRI Technologist BEFORE entering the MRI exam room.

DO YOU HAVE ANY OF THE FOLLOWING?

☐YES ☐NO Injury to your eye involving metal
☐YES ☐NO Any metallic fragment or foreign body
☐YES ☐NO Aneurysm clip(s)
☐YES ☐NO Cardiac pacemaker
☐YES ☐NO Implanted cardioverter defibrillator (ICD)
☐YES ☐NO Electronic implant or device
☐YES ☐NO Magnetically-activated implant or device
☐YES ☐NO Neurostimulation system
☐YES ☐NO Spinal cord stimulator
☐YES ☐NO Internal electrodes or wires
☐YES ☐NO Bone growth / bone fusion stimulator
☐YES ☐NO Cochlear, otologic or other ear implant
☐YES ☐NO Insulin or other infusion pump
☐YES ☐NO Implanted drug infusion device
☐YES ☐NO Any type of prosthesis (eye, penile, etc.)
☐YES ☐NO Heart valve prosthesis
☐YES ☐NO Eyelid spring or wire
☐YES ☐NO Artificial or prosthetic limb
☐YES ☐NO Metallic stent, filter or coil
☐YES ☐NO Shunt (spinal or intraventricular)
☐YES ☐NO Vascular access port and/or catheter
☐YES ☐NO Radiation seeds or implants
☐YES ☐NO Swan-Ganz or thermodilution catheter
☐YES ☐NO Medication patch (Nicotine, Nitroglycerine, etc.)
☐YES ☐NO Wire mesh implant
☐YES ☐NO Tissue expander (breast or other)
☐YES ☐NO Surgical staples, clips or metallic sutures
☐YES ☐NO Joint replacement (hip, knee, etc.)
☐YES ☐NO Bone/joint pin, screw, nail, wire, plate, etc.
☐YES ☐NO IUD, diaphragm or pessary
☐YES ☐NO Other implant: _____
☐YES ☐NO Dentures or partial plates
☐YES ☐NO Tattoo or permanent makeup
☐YES ☐NO Body piercing jewelry
☐YES ☐NO Hearing aid (remove before entering exam room)
☐YES ☐NO Breathing problem or motion disorder
☐YES ☐NO Claustrophobia

IMPORTANT INSTRUCTIONS

Mark on the figure below the location of any implant or metal inside of or on your body



Remove ALL metallic objects in the dressing room, including:

- hearing aids
- dentures and partial plates
- cell phone and pagers
- keys
- eyeglasses
- hair pins and barrettes
- jewelry and watch, including body piercing jewelry
- safety pins
- money clip and coins
- credit cards, bank cards and magnetic strip cards
- pens
- pocket knife
- nail clipper
- clothing with metal fasteners and metallic threads
- steel-toed boots/shoes
- tools
- all loose metallic objects

★ Consult the MRI Technologist if you have any questions or concerns BEFORE you enter the exam

Technologist Notes:

★ All patients having MRI studies MUST wear hearing protection (ear plugs or ear muffs). No exceptions.

PREGNANCY and BREASTFEEDING STATUS

★ If a mother desires, she may refrain from breastfeeding for 24 hours and discard milk after gadolinium injections.

Are you: **Pregnant?** ☐ Yes ☐ No **Possibly Pregnant?** ☐ Yes ☐ No **Breast Feeding?** ☐ Yes ☐ No

Date of Last Menstrual Period: _____

SKIN WARMING

★ MRI Radiofrequency has the potential to cause tissue heating. Precautions will be taken to avoid this.
Alert the technologist immediately if you notice any heating sensations during your MRI scan.

PIERCINGS, COSMETIC IMPLANTS, TATTOOS AND PERMANENT MAKEUP

★ A small number of patients have experienced transient skin irritation, swelling, bruising or heating sensations at the site of piercings, cosmetic implants, tattoos and permanent makeup in association with MR procedures.
Individuals with these items should inform the technologist so precautions can be taken.

MEDICAL HISTORY

Why are you having this test done? What is the reason?

_____

Where/What area is the problem? Body part involved?

_____

Which side (left/right/upper/lower)? _____

When did your symptoms start? _____

Describe the problem it is giving you. _____

_____

_____

Check all that are applicable to your symptoms:

☐ Acute (present or a severe and intense degree)
☐ Chronic (persisting a long time / constantly recurring)
☐ Intermittent ☐ Transient (lasts only a short time)
☐ Primary Issue ☐ Secondary due to another issue

List any tests you had at other facilities for this problem:
Ex: Lab, X-Ray, Upper GI, BE, Ultrasound, MRI, CT
Test – Date – Where

_____

_____

List surgeries you have had and date of surgery:

_____

_____

Do you have or ever had cancer? ☐ Yes ☐ No
If yes: What Type – Where (body part)

_____

What type of treatment did you receive and when?

_____

Did you injure the area of interest? ☐ Yes ☐ No
If yes, describe: _____

List all medications you are taking and what they're for:

_____

_____

Have you been in the hospital within the last week?
☐ Yes ☐ No If yes, describe below:

_____

Have you ever experienced any problem related to a previous MRI procedure or MRI contrast? ☐ Yes ☐ No

_____

DO YOU HAVE ANY OF THE FOLLOWING?	TECHNOLOGIST NOTES
☐ YES ☐ NO Kidney disease or kidney injury	_____
☐ YES ☐ NO Kidney surgery, transplant, single kidney	_____
☐ YES ☐ NO Kidney tumor or cancer	_____
☐ YES ☐ NO Diabetes	_____
☐ YES ☐ NO Are on dialysis	_____
☐ YES ☐ NO Chemotherapy in the past 3 months	_____
☐ YES ☐ NO Take medication for hypertension (follow local protocol)	_____
☐ YES ☐ NO Past allergic reaction to gadolinium or iodine contrast	_____
☐ YES ☐ NO Asthma or allergy	_____

CONTRAST CONSENT

Due to your medical history, or as requested by your physician, an injection of MRI gadolinium contrast may be necessary to aid the radiologist in evaluating your MRI scan.

The Food and Drug Administration has approved this agent. A very small percentage of patients receiving gadolinium may develop a headache or experience mild nausea. Rarely, local inflammation may occur at the injection site.

☐ I CONSENT to having Gadolinium contrast as needed. (Check box if you agree to contrast)
☐ I DECLINE having a Gadolinium contrast injection at this time. (Check box if you disagree to contrast)

I attest that the information on this form is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the MR procedure I am about to undergo.
I understand that emergency or follow-up care, if needed, is the direct financial responsibility of the patient receiving additional 3rd party services (ambulance transport to a hospital, 911 call, medical care, etc.).

Patient/Guardian Signature: _____ Date: _____

FOR STAFF USE: Screening Performed By: ☐ MR Technologist ☐ Nurse ☐ Radiologist ☐ Other: _____

Staff Signature: _____ Print Name: _____