



MRI PROCEDURE SCREENING FORM

THE FOLLOWING ITEMS MAY BE HARMFUL TO YOU DURING YOUR MR SCAN OR MAY INTERFERE WITH THE MR EXAMINATION.

Date: ___/___/___ Name: _____ Date of Birth: ___/___/___ Age: ___

Weight: _____ Procedure: _____

Reason for test: _____

PREVIOUS SURGERY: Brain? _____ Heart? _____ Spine? _____ If yes, state year.

PLEASE LIST ALL OTHER SURGERIES AND DATES: _____

Please indicate if you have any of the following. You must provide a YES or NO for every item.

YES NO

- ___ ___ Claustrophobia
___ ___ Pacemaker
___ ___ Intracranial (Brain) Aneurysm Clips
___ ___ Worked in a machine shop (grinding/cutting metal)
___ ___ Shrapnel or bullets
___ ___ Neurostimulator, bone growth or Vagul stimulator
___ ___ Internal electrodes or wires
___ ___ Implanted drug pump (e.g. insulin, chemotherapy, pain medicine)
___ ___ Eye implant
___ ___ Cochlear ear implant
___ ___ Liver transplant recipient or waiting for liver transplant?
___ ___ Prosthetic heart valves, filters or stents? If yes, date of implant _____
___ ___ Any implant in the body (joints, metal, other)
___ ___ How many years? ___ Where in the body? _____
___ ___ Hearing aid
___ ___ Dentures or partial plate
___ ___ Tattoo or permanent make up
___ ___ Are you diabetic? Are you on dialysis? ___ Any history of kidney disease? ___
___ ___ Cancer? If yes, type and year: _____
___ ___ Previous exam related to this test? (i.e. MRI, CT, Ultrasound, Nuc Med, X-ray)
___ ___ Type of exam _____ Facility _____

FEMALE PATIENTS

___ ___ Is there any chance that you may be pregnant? Are you breastfeeding? ___

MALE PATIENTS

___ ___ Penile Implant

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form, and I have had the opportunity to ask questions regarding the information on this form.

Patient signature: _____ Date: _____



MRI CONSENT FOR CONTRAST INJECTION

PATIENTS NAME _____ MR# _____ AGE _____

The procedure(s) necessary to treat my condition has/have been explained to me by a licensed medical professional and I understand the nature of the procedure to be: Insertion of a needle into the vein of the arm to inject Gadolinium contrast which goes into the blood stream. The contrast is given to help visualize the anatomy in more detail, which assists the radiologist with his diagnosis.

1. I have been made aware of certain risk(s) and consequences that are associated with the procedure described above. These are: Allergy to Gadolinium contrast: i.e. itching, hives, nausea and/or vomiting. Swelling and breathing problems can be fatal, but are very rare. Nephrogenic Systemic Fibrosis (NSF) can occur in people with kidney disease, but is extremely rare. NSF causes skin tightening and pain, usually in the extremities and in extreme cases can result in death.
2. I certify that I have read the above paragraphs and understand them. I authorize the procedure described above.
3. I, hereby, give consent for the injection of Gadolinium contrast and fully understand the above.

X _____
SIGNATURE OF PATIENT OR GUARDIAN

DATE _____

RELATIONSHIP TO PATIENT

WITNESS _____

RADIOLOGIST _____

Tech Use Only

GFR _____

Creatine _____

Contrast Amount _____

Contrast Type _____

IV Site _____