SJRA
SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete
DOS: _____

MRI SCREENING FORM

PATIENT #: _____
PATIENT NAME: _____
DOB: ____ / ____ / ____ / AGE: ____ / SEX: ___

HEIGHT: WEIGHT:

WARNING: Certain implants, devices, or objects may be hazardous to you, and/or may interfere with the MR procedure. DO NOT ENTER the MR System room or MR environment if you have any questions or concerns regarding an implant, device or object. Consult the MRI technologist or Radiologist BEFORE entering the MR room. The MR system magnet is ALWAYS ON.

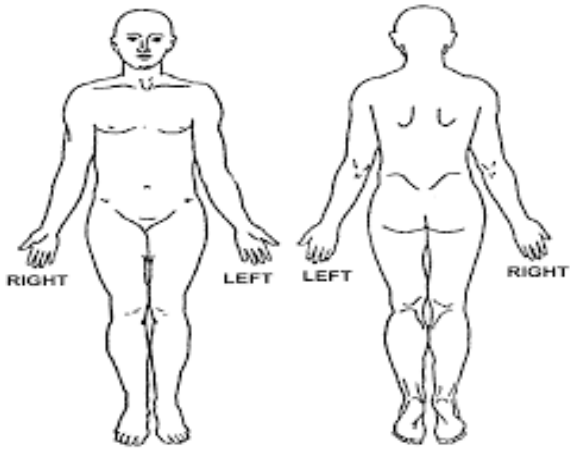
Please indicate if you have any of the following:

□ 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 Neurostimulator or bone stimulator
□ Yes □ No Brace, splint or other joint support
□ Yes □ No Internal electrodes or residual wires
□ Yes □ No Cochlear, otologic, or other ear implant
□ Yes □ No Insulin or other infusion pump
□ Yes □ No Morphine infusion pump
□ Yes □ No Penile prosthesis
□ Yes □ No Heart valve prosthesis
□ Yes □ No History of eye or retina surgery
□ Yes □ No Artificial or prosthetic limb
□ Yes □ No Abdominal aortic aneurysm stent graft
□ Yes □ No Shunt (spinal or intraventricular)
□ Yes □ No Radiation seeds or implants
□ Yes □ No Medication patch (Nicotine, Nitroglycerin)
□ Yes □ No Any metallic fragment or foreign body
□ Yes □ No Wire mesh implant
□ Yes □ No Breast tissue expander
□ 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
□ Yes □ No Dentures or partial plates
□ Yes □ No Body piercing jewelry
□ Yes □ No Hearing aid (Remove before entering
□ Yes □ No Breathing problem or motion disorder
□ Yes □ No Claustrophobia (Afraid of confined spaces)
□ Yes □ No **Have you ever been injured by any metallic object (e.g. bullet, shrapnel, BB, etc.)?**
□ Yes □ No **Have you ever had an eye injury involving a metallic object (e.g. metallic slivers, shavings, etc.)?**

IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove ALL metallic objects including cell phones, **ALL JEWELRY**, hearing aids, dentures, partial plates, keys, eyeglasses, hair pins, barrettes, body piercings, watches, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools. Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE YOU ENTER THE MRI SYSTEM ROOM. Lockers will be provided before entering the MRI Suite (Glasses, dental work, shoes can remain with you until you enter the room). ***For your safety, you will be asked to change into a gown.***

PLEASE MARK ON THE FIGURE BELOW THE LOCATION OF IMPLANTS OR METAL INSIDE OF OR ON YOUR BODY



Note: You may be advised to wear earplugs or other hearing protection during the MRI to prevent possible problems related to noise. MRI is generally a safe procedure. Qualified medical personnel will be present throughout procedure.

I attest that the above information 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 information on this form. By signing below I agree to gadolinium contrast injection.

Signature of Person Completing Form: _____ Date: _____

If Form Completed By Someone Other than the Patient (Print name): _____

Relationship: _____

PATIENT #: _____
PATIENT NAME: _____
DOB: ____ / ____ / ____ / AGE: ____ / SEX: ___

Patient MUST Complete
DOS: _____

MRI CONTRAST FORM

Your doctor has asked that your symptoms be evaluated with an MRI study with gadolinium intravenous contrast. Gadolinium contrast is given by injection into a vein and helps provide the radiologist with additional information that may not be available without intravenous contrast.

The gadolinium contrast agent you will receive has been approved as safe and effective by the U.S. Food and Drug Administration (FDA). As with any medication, a small chance exists that you may have a reaction to it. Minor and temporary reactions include pain at the injection site, nausea, headache, dizziness, itching, rash or hives. Rarely, a true allergic reaction may occur (including facial swelling, difficulty breathing, or low blood pressure) requiring treatment. The odd of an extremely severe reaction, including death, is very rare. There is also an extremely rare disease called Nephrogenic Systemic Fibrosis that has occurred in patients with kidney failure. As such, we screen at-risk patients by obtaining kidney function studies prior to contrast injection.

Your chances of a reaction may be increased if you have had a previous allergic reaction to gadolinium, are allergic to other drugs or foods, have asthma, or suffer from kidney disease. Please inform the MR technologist if any of these situations apply to you.

Please answer the questions below.

Please list all allergies: _____
□ Yes □ No - Do you have asthma?
□ Yes □ No - Do you have an allergy to CT (iodinated contrast) or MRI (gadolinium) contrast? (If yes, circle which one)
If yes, when and what happened? _____
□ Yes □ No - Have you ever had an anaphylactic reaction (severe allergic reaction where you had to be hospitalized)?
If yes, when and what happened?_____

Are you currently on dialysis?	□ Yes □ No	Have you ever had kidney disease or kidney cancer?	□ Yes □ No
Have you had a kidney transplant?	□ Yes □ No	Are you a diabetic on insulin or prescribed medication?	□ Yes □ No
Have you ever had kidney surgery?	□ Yes □ No	Do you have only one kidney?	□ Yes □ No

FOR WOMEN:

Are you breast feeding?	□ Yes □ No
Are you receiving hormone treatment?	□ Yes □ No

I attest that the above information 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 information on this form. By signing below I agree to gadolinium contrast injection.

Signature of Person Completing Form: _____)_____ Date: _____

If Form Completed By Someone Other than the Patient (Print name): _____

Relationship: _____

TECHNOLOGIST USE ONLY

IV Contrast: _____ cc (Circle) Omniscan Multihance Other:_____

Comments: _____

_____

_____

_____ MRI Technologist_____

PATIENT #: _____
PATIENT NAME: _____
DOB: ____ / ____ / ____ / AGE: ____ / SEX: ___

Patient MUST Complete
DOS: _____

MRI BREAST HISTORY

EXAM HISTORY

Is this your first Breast MRI? N ☐ / Y ☐

Reason for today's exam: ☐ Screening (no current problems) ☐ Diagnostic (new problem or follow up)

Explain: _____

Where and when was your last *Mammogram*? ☐ SJRA ☐ Other: _____ Date: _____
Where and when was your last *Breast Ultrasound*? ☐ SJRA ☐ Other: _____ Date: _____
Where and when was your last *Breast MRI*? ☐ SJRA ☐ Other: _____ Date: _____
When was the last time you had a breast examination performed by a doctor? _____

CURRENT SYMPTOMS

Are you having any problem with your breasts? N ☐ / Y ☐

	Which Breast	Duration
☐ Lump	☐ **R** / ☐ **L**	_____
☐ Tenderness	☐ **R** / ☐ **L**	_____
☐ Discharge (clear, bloody, milky)	☐ **R** / ☐ **L**	_____
☐ Skin (changes/itching)	☐ **R** / ☐ **L**	_____
☐ Nipple Inversion	☐ **R** / ☐ **L**	_____
☐ Thickening	☐ **R** / ☐ **L**	_____

Please describe any other symptoms you may be experiencing: _____

HISTORY OF CANCER

Do you have a family history of breast cancer? N ☐ / Y ☐
Relation of family member (mother, grandmother, etc) _____
What age was he / she diagnosed? _____

Have you been diagnosed with *BREAST* Cancer? N ☐ / Y ☐
Type: _____ Date: _____
Specify breast: ☐ **R** / ☐ **L**

Did you undergo treatment? N ☐ / Y ☐
☐ Lumpectomy ☐ Radiation ☐ Mastectomy ☐ Chemotherapy
☐ Hormone Therapy Type: _____

Have you had *ANY* other type of cancer? N ☐ / Y ☐
Type: _____ Date: _____

Have you had implant surgery? N ☐ / Y ☐
Silicone ☐ Saline ☐ Date(s)? _____

Have you had your breast cancer risk assessed? N ☐ / Y ☐
Results : _____

Have you had a trauma to the breast (causing black or blue marks)? N ☐ / Y ☐
☐ **R** / ☐ **L** Date: _____

Have you had any breast procedures or breast surgery? N ☐ / Y ☐

***Please list any surgical biopsies, core biopsies, aspirations, breast reduction surgeries, etc.* INCLUDE RESULTS:**

RIGHT BREAST	LEFT BREAST
Date: _____ Type: _____	Date: _____ Type: _____
Date: _____ Type: _____	Date: _____ Type: _____
Date: _____ Type: _____	Date: _____ Type: _____

HORMONE HISTORY (FEMALE ONLY)

Have you taken hormone replacement therapy? N ☐ Y ☐
Duration: _____ to _____
Are you: ☐ Premenopausal ☐ Perimenopausal ☐ Postmenopausal ***Last menstrual period:*** _____

Have you ever been pregnant? N ☐ / Y ☐
How many times? _____ How many live births? _____ Age at first birth? _____

Are you currently pregnant or trying to get pregnant? N ☐ / Y ☐

Have you breast fed in the last 3 months? N ☐ / Y ☐

Have you had a hysterectomy (removal of uterus)? N ☐ / Y ☐

Have you had an oopherectomy (removal of ovaries)? One ☐ Both ☐ N ☐ / Y ☐

Has your weight changed since your last mammogram? N ☐ / Y ☐
Specify: ☐ Gain ☐ Loss Amount: _____

Tech Signature: _____ **Patient Signature: X**_____