

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:

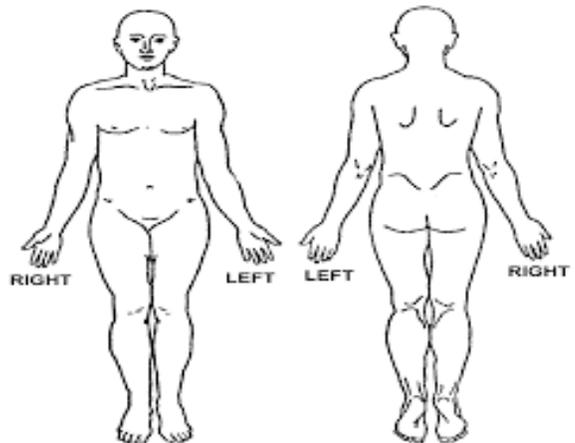
- Yes No Aneurysm clip(s)
- Yes No Cardiac pacemaker
- Yes No Implanted cardioverter defibrillator (ICD)
- Yes No Electronic implant or device
- Yes No Magnetically-activated implant or device
- Yes No Neurostimulator or bone stimulator
- Yes No Brace, splint or other joint support
- Yes No Internal 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: _____			
<input type="checkbox"/> Yes <input type="checkbox"/> No - Do you have asthma?			
<input type="checkbox"/> Yes <input type="checkbox"/> 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? _____			
<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever had kidney disease or kidney cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had a kidney transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you a diabetic on insulin or prescribed medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had kidney surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have only one kidney?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

BREAST MRI EXAMINATION

Are you having the MRI to evaluate a specific problem with your breast?

- No, this is for screening only.
- Yes; if so, please explain: _____

Where and when was your last mammogram? Where: _____ When: _____

Results: _____
(If you brought films with you, leave them with the technologist. Please call the office 48 hours following your study to arrange pickup. If you did not bring films, they may be requested for correlation with the MRI.)

Have you had a recent breast ultrasound examination? Where: _____ When: _____

Results: _____

Have you ever had a breast biopsy (surgical biopsy or needle biopsy), or other breast surgery (including implants, reductions or reconstruction)?

- No
- Yes, Right Breast Date: _____ Results: _____
- Yes, Left Breast Date: _____ Results: _____

If you have breast implants, please specify date of surgery and type of implant (silicone, Saline, Double lumen, etc): When? _____ What type: _____

Have you ever had breast cancer?

- No
- Yes, Right Breast Date: _____ Treatment: Lumpectomy Radiation Chemo
- Yes, Left Breast Date: _____ Treatment: Lumpectomy Radiation Chemo

Have you had any other kind of cancer?

Has a family member had breast cancer?

- No Yes, which relative(s), at what age(s): _____

How many pregnancies have you had? _____ **Age at first pregnancy:** _____

Are you (please check one): before menopause after Menopause

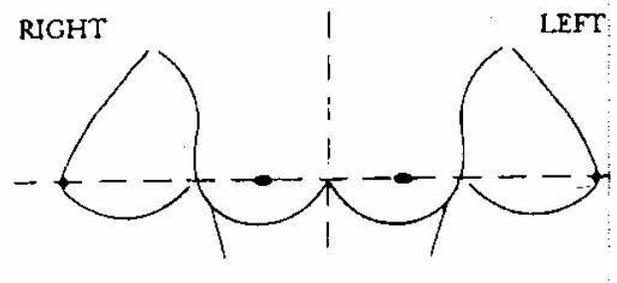
Last menstrual period was: _____ **Any chance you could be pregnant?** No Yes

Are you taking any type of hormones (including estrogen replacement or birth control pills)?

- No Yes, for how long? _____ What type? _____

Patient Signature: _____

TECHNOLOGIST: Please mark scars ~~///~~ and lumps ●



PLACE VITAMIN E ON BREAST FOR LUMPS

Patient MUST Complete
DOS: _____

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

Patient Accompanied By: _____

CONSENT FOR INVASIVE RADIOGRAPHIC PROCEDURE(S)

I _____ AUTHORIZE Dr. _____ and/or His/her associates and such assistants as may be selected by him/her to perform upon me (or the above named patient) the following Radiology procedures(s):

The Radiologist has adequately explained to me the medically significant risks and possible complications that are or may be associated with this procedure, and the alternatives, if any. I have has the opportunity to fully discuss these matters. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me about the results of the radiology procedure.

I certify that I have read and fully understand the above consent which has been preceded by an explanation by the Radiologist. I acknowledge and an satisfied that I have been adequately informed concerning material risks, possible complications and alternatives, if any, of this procedure and specifically consent to such.

Signature of Patient

Date / Time

_____ AM / PM

Witness

In the event the above named patient is an un-emancipated minor, or is unable to sign for the following reason(s).

Signature of Patient

Date / Time

_____ AM / PM

Witness