Effective Date: December 23, 2015

MRI PATIENT HISTORY AND CONSENT FORM

Patient Name: ______________________________ Medical Record #: ________________

Imaging Center: ______________________________ Date of Exam: ________________

Body Part to be Examined: ________________ Reason for MRI: ________________

Referring Dr.: ______________ Dr. Phone #: ____________ ________________

Date of Birth: ______________ Age: ________ Height: __________ Weight: ____________

☐ Male ☐ Female If Female, Last Menstrual Period: ______________ Postmenopausal: ☐ Yes ☐ No

Have you taken any anxiety or sedation medication today? ☐ Yes ☐ No If yes, what? ____________

★ THE ITEMS BELOW CAN INTERFERE WITH MR IMAGING - SOME CAN BE HAZARDOUS TO YOUR SAFETY

Have you ever had: An injury to your eye involving metal? ☐ Yes ☐ No

A metallic fragment or foreign body in your head, face, neck or body? ☐ Yes ☐ No

If yes to either question above, were you tested to ensure all metal was removed? ☐ Yes ☐ No

SURGICAL IMPLANTS	YES	NO	SURGICAL IMPLANTS	YES	NO
Cardiac Pacemaker	☐	☐	Breast (or other) Tissue Expander	☐	☐
Pacemaker Wires	☐	☐	Breast Implants	☐	☐
Electronic Implant or Device	☐	☐	Neurostimulator	☐	☐
Spinal Cord Stimulator	☐	☐	Implanted Cardiac Defibrillator	☐	☐
Cochlear, Otologic or Ear Implant	☐	☐	Bone Growth Stimulator	☐	☐
Internal Electrodes or Wires	☐	☐	Aneurysm Clip	☐	☐
Eyelid Spring or Wire	☐	☐	Magnetically Activated Implant or Device	☐	☐
Cardiac Stent	☐	☐	Swan-Ganz or Thermodilution Catheter	☐	☐
Artificial Heart Valve	☐	☐	Clips in Blood Vessel	☐	☐
Endoscopy Camera Pill	☐	☐	Implanted Drug Infusion Device/Pump	☐	☐
Stent / Coil / Filter	☐	☐	IVC Filter / Venous Umbrella	☐	☐
Wire in Blood Vessel	☐	☐	Pessary or Bladder Ring	☐	☐
Any Magnetic Implant	☐	☐	Any Metallic Fragment or Foreign Body	☐	☐
Shunt (spinal or intraventricular)	☐	☐	Transdermal Medication Patch (Nitro, Nicotine)	☐	☐
Prosthesis (eye, penile, etc)	☐	☐	Bone/Joint Pin, Screw, Nail, Wire, Plate, etc	☐	☐
Radiation Seeds or Implants	☐	☐	Harrington Rod (spine)	☐	☐
Artificial Limb	☐	☐	Wire Mesh Implant	☐	☐
Joint Replacement	☐	☐	Surgical Staples, Clips or Metallic Sutures	☐	☐
Tens Unit	☐	☐	Tattoo or Permanent Makeup	☐	☐
Vascular Access Port/Catheter	☐	☐	Dentures or Partial Plates	☐	☐
IUD or Diaphragm	☐	☐	Hearing Aid (remove before scan)	☐	☐
Body Piercing Jewelry	☐	☐	Claustrophobia	☐	☐

★ HEARING PROTECTION - All patients having MRI studies MUST wear hearing protection, no exceptions.

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. **Check YES or NO for each item.**

DO YOU HAVE	YES	NO	TECHNOLOGIST NOTES
Kidney disease or kidney injury	☐	☐	____________
Kidney surgery, transplant, single kidney	☐	☐	____________
Kidney tumor or cancer	☐	☐	____________
Are you on dialysis	☐	☐	____________
Hypertension requiring medicine	☐	☐	____________
Diabetes	☐	☐	

Have you ever had an allergic reaction to: MRI contrast? ☐ Yes ☐ No Iodine contrast? ☐ Yes ☐ No

Do you have Asthma? ☐ Yes ☐ No List any allergies: ____________________

☐ 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)

Patient/Guardian Signature: ____________________ **Technologist Signature:** ____________________

Patient Name: ____________________ Date of Exam: ____________

Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist BEFORE entering the MRI exam room. The MR system magnet is ALWAYS on.

PREGNANCY STATUS

★ If the 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

SKIN WARMING

★ MRI Radiofrequency has the potential to cause tissue heating. The Technologist will take several precautions 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.**

INJURY / SURGICAL / RADIATION HISTORY

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

Have you had another exam of the area we are scanning? ☐ Yes ☐ No If yes, describe what/when/where below:

Have you had surgery or radiation therapy on the area we are scanning? ☐ Yes ☐ No If yes, describe below:

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

CHECK ALL SYMPTOMS RELATED TO THE TYPE OF MRI SCAN YOU ARE HAVING TODAY

ABDOMEN
- ☐ Abdominal Pain - Describe below: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning
- ☐ Difficulty Swallowing
- ☐ Loss of Appetite
- ☐ Nausea / Vomiting
- ☐ Bowel or Bladder Changes
- ☐ Weight Loss or Gain

MALE PELVIS
- ☐ Pain
- ☐ Lump or Mass
- ☐ Trauma
- ☐ Pelvic Surgery
- ☐ Implant
- ☐ Hematuria
- ☐ Cancer
- ☐ Steroid or Radiation Therapy

NECK (Soft Tissue)
- ☐ Lump or Mass
- ☐ Difficulty Swallowing
- ☐ Difficulty Talking
- ☐ Pain
- ☐ Sore Throat

BRAIN / IAC
- ☐ Headaches
- ☐ Seizures
- ☐ Weakness
- ☐ Trouble Walking
- ☐ Dizziness
- ☐ Speech Problem/Trouble Talking
- ☐ Hearing Problem ☐ Right ☐ Left
- ☐ Visual Problem ☐ Right ☐ Left
- ☐ Memory Loss

SHOULDER / ARM / ELBOW / HAND HIP / LEG / ANKLE / FOOT
- ☐ Right Body Part: ____________
- ☐ Left
- ☐ Limited Range of Motion
- ☐ Numbness
- ☐ Weakness
- ☐ Popping
- ☐ Grinding
- ☐ Swelling
- ☐ Lump or Mass
- ☐ Pain - Describe Below: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning

FEMALE PELVIS
- ☐ Irregular Menstruation
- ☐ Painful Menstrual Cycles
- ☐ Painful Intercourse
- ☐ Hysterectomy
- ☐ Ovaries Removed

SPINE Cervical / Thoracic / Lumbar
- ☐ Back Pain - Describe below: ☐ Upper ☐ Middle ☐ Lower ☐ Dull ☐ Sharp ☐ Both
- ☐ Neck Pain - Describe below: ☐ Dull ☐ Sharp ☐ Both
- ☐ Weakness in: ☐ R Arm ☐ L Arm ☐ R Leg ☐ L Leg
- ☐ Pain in: ☐ R Arm ☐ L Arm ☐ R Leg ☐ L Leg
- ☐ Numbness in: ☐ R Arm ☐ L Arm ☐ R Leg ☐ L Leg

CHEST
- ☐ Difficulty Breathing
- ☐ Chest Tightness / Chest Pain
- ☐ Moist Cough ☐ Dry Cough
- ☐ Heart Disease

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.

Patient/Guardian Signature: ____________________ **Today's Date**: ____________

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

Staff Signature: ____________________ Print Name: ____________________