Facility: _____

MRI HISTORY and CONSENT FORM

FORM.POL.002
Effective Date: July 11, 2013

Patient's Name: _____ Date of Exam: _____

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

Referring Dr.: _____ Dr. Phone #: _____ Medical Record #: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

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

★ THESE ITEMS CAN INTERFERE WITH MR IMAGING AND SOME CAN BE HAZARDOUS TO YOUR SAFETY. Please check YES or NO for each item.

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	☐	☐	Aneurysm Clip	☐	☐
Pacemaker Wires	☐	☐	Neurostimulator	☐	☐
Electronic Implant or Device	☐	☐	Implanted Cardiac Defibrillator	☐	☐
Spinal Cord Stimulator	☐	☐	Bone Fusion or Bone Growth Stimulator	☐	☐
Cochlear, Otologic or Ear Implant	☐	☐	Tissue Expander (e.g. breast)	☐	☐
Internal Electrodes or Wires	☐	☐	Magnetically Activated Implant or Device	☐	☐
Eyelid Spring or Wire	☐	☐	Swan-Ganz or Thermodilution Catheter	☐	☐
Cardiac Stent	☐	☐	Clips in Blood Vessel	☐	☐
Artifical Heart Valve	☐	☐	Implanted Drug Infusion Device/Pump	☐	☐
Endoscopy Camera Pill	☐	☐	Venous Umbrella	☐	☐
Coil, Filter, Wire in Blood Vessel	☐	☐	Pessary or Bladder Ring	☐	☐
Stent in Blood Vessel	☐	☐	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 / Joint Replacement	☐	☐	Wire Mesh Implant	☐	☐
Tens Unit	☐	☐	Surgical Staples, Clips or Metallic Sutures	☐	☐
Vascular Access Port/Catheter	☐	☐	Tattoo or Permanent Makeup	☐	☐
IUD or Diaphragm	☐	☐	Dentures or Partial Plates	☐	☐
Body Piercing Jewelry	☐	☐	Hearing Aid (remove before scan)	☐	☐
Motion Disorder	☐	☐	Claustrophobia	☐	☐

HEARING PROTECTION

★ All patients having MRI studies must wear hearing protection.

Ear protection is offered in various forms: earplugs, noise reduction headsets, noise cancellation technology.

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 Problems	☐	☐	
Liver Problems	☐	☐	
Asthma or a Respiratory Disease	☐	☐	
Diabetes	☐	☐	

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

List all known 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: _____

MRI HISTORY and CONSENT FORM

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

★ It is a recommendation to discontinue breast feeding and discard breast milk for 24 hours 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.**

TATTOOS AND PERMANENT MAKEUP

★ A small number of patients with tattoos have experienced transient skin irritation, swelling, or heating sensations at the site of the permanent colorings in association with MR procedures. **Individuals with tattoos or permanent makeup should inform the technologist so appropriate 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:

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

HIP / LEG / KNEE /ANKLE / FOOT

☐ Right
☐ Left
☐ Locking ☐ Clicking
☐ Giving Away ☐ Swelling
☐ Numbness ☐ Weakness
☐ Lump or Mass
☐ Pain - Describe below:
☐ Sharp ☐ Dull ☐ Aching ☐ Burning

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

ARM / SHOULDER / ELBOW / WRIST / HAND

☐ Right
☐ 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: _____