Facility Name: ______________________________
Address: ______________________________
City, State ZIP: ______________________________

MRI PATIENT HISTORY AND CONSENT

Effective Date: August 24, 2017

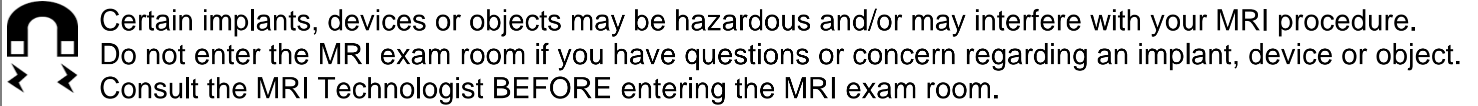
PATIENT DEMOGRAPHICS

Patient Name: ______________________________ Medical Record #: ______________________________

Date of Exam: ______________________________ Referring Dr.: ______________________________

Date of Birth: ________________ Age: _______ Height: _________ Weight: ___________ ☐ Male ☐ Female

WARNING: THE MRI SYSTEM MAGNET IS ALWAYS ON



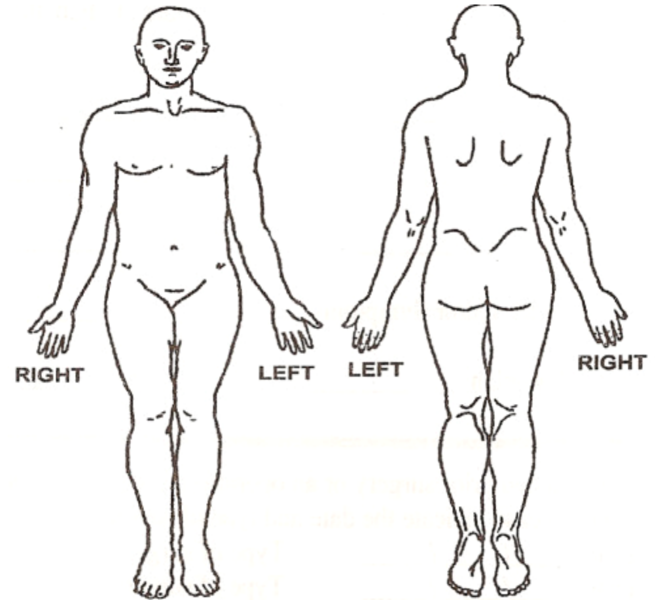
Certain implants, devices or objects may be hazardous and/or may interfere with your MRI procedure.
Do not enter the MRI exam room if you have questions or concern regarding an implant, device or object.
Consult the MRI Technologist BEFORE entering the MRI exam room.

DO YOU HAVE ANY OF THE FOLLOWING?

- ☐ YES ☐ NO Injury to your eye involving metal
- ☐ YES ☐ NO Any metallic fragment or foreign body
- ☐ 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 Neurostimulation system
- ☐ YES ☐ NO Spinal cord stimulator
- ☐ YES ☐ NO Internal electrodes or wires
- ☐ YES ☐ NO Bone growth / bone fusion stimulator
- ☐ YES ☐ NO Cochlear, otologic or other ear implant
- ☐ YES ☐ NO Insulin or other infusion pump
- ☐ YES ☐ NO Implanted drug infusion device
- ☐ YES ☐ NO Any type of prosthesis (eye, penile, etc.)
- ☐ YES ☐ NO Heart valve prosthesis
- ☐ YES ☐ NO Eyelid spring or wire
- ☐ YES ☐ NO Artificial or prosthetic limb
- ☐ YES ☐ NO Metallic stent, filter or coil
- ☐ YES ☐ NO Shunt (spinal or intraventricular)
- ☐ YES ☐ NO Vascular access port and/or catheter
- ☐ YES ☐ NO Radiation seeds or implants
- ☐ YES ☐ NO Swan-Ganz or thermodilution catheter
- ☐ YES ☐ NO Medication patch (Nicotine, Nitroglycerine, etc.)
- ☐ YES ☐ NO Wire mesh implant
- ☐ YES ☐ NO Tissue expander (breast or other)
- ☐ 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, diaphragm or pessary
- ☐ YES ☐ NO Other implant: ____________________
- ☐ YES ☐ NO Dentures or partial plates
- ☐ YES ☐ NO Tattoo or permanent makeup
- ☐ YES ☐ NO Body piercing jewelry
- ☐ YES ☐ NO Hearing aid (remove before entering exam room)
- ☐ YES ☐ NO Breathing problem or motion disorder
- ☐ YES ☐ NO Claustrophobia

IMPORTANT INSTRUCTIONS

Mark on the figure below the location of any implant or metal inside of or on your body



Remove ALL metallic objects in the dressing room, including:

- hearing aids
- cell phone, pager
- eyeglasses
- safety pins
- pens
- pocket knife
- dentures and partial plates
- keys
- hair pins and barrettes
- money clip and coins
- tools
- nail clipper
- steel-toe boots/shoes
- jewelry and watch, including body piercing jewelry
- credit cards, bank cards and magnetic strip cards
- clothing with metal fasteners and metallic threads
- all loose metallic objects

TECHNOLOGIST NOTES

SKIN WARMING

★ MRI Radiofrequency has the potential to cause tissue heating. Precautions will be taken to avoid this. **Alert the technologist immediately if you notice any heating sensations during your MRI scan.**

HEARING PROTECTION

★ **All patients having MRI studies MUST wear Hearing Protection** (ear plugs or ear muffs). **No exceptions.**

PREGNANCY and BREASTFEEDING STATUS

★ If a 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

Date of Last Menstrual Period: ______________________________

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.**

MEDICAL HISTORY

Why are you having this test done? What is the reason?

____

Where/What area is the problem? Body part involved?

____

____

Which side (left/right/upper/lower)? ______________

When did your symptoms start? ______________

Describe the problem it is giving you. ______________

____

____

Check all that are applicable to your symptoms:

☐ Acute (present or a severe and intense degree)

☐ Chronic (persisting a long time / constantly recurring)

☐ Intermittent ☐ Transient (lasts only a short time)

☐ Primary Issue ☐ Secondary due to another issue

List any tests you had at other facilities for this problem:
Ex: Lab, X-Ray, Upper GI, BE, Ultrasound, MRI, CT

Test – Date – Where

____

____

List surgeries you have had and date of surgery:

____

____

____

Do you have or ever had cancer? ☐ Yes ☐ No

If yes: What Type – Where (body part)

____

What type of treatment did you receive and when?

____

Did you injure the area of interest? ☐ Yes ☐ No

If yes, describe: ______________________________

List all medications you are taking and what they're for:

____

____

Have you been in the hospital within the last week?

☐ Yes ☐ No If yes, describe below:

____

Have you ever experienced any problem related to a previous MRI procedure or MRI contrast? ☐ Yes ☐ No

____

DO YOU HAVE ANY OF THE FOLLOWING?	TECHNOLOGIST NOTES
☐ YES ☐ NO Past allergic reaction to gadolinium or iodine contrast	
☐ YES ☐ NO Asthma or allergy	
☐ YES ☐ NO Are you on renal dialysis	

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 contrast agent is given through a small needle placed into a vein, usually on the inside of your elbow or on the back of your hand. The Food and Drug Administration has approved this agent and it is considered quite safe; however any injection carries a risk of harm, including injury to a nerve, artery or vein, extravasation of the contrast under the skin, infection, potential of renal injury; or reaction to the contrast itself.

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. Uncommonly, more serious reactions have been known to occur, including life-threatening reactions. These serious reactions are rare.

☐ 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)

Consult the MRI Technologist if you have any questions or concerns BEFORE you enter the exam room

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: ______________________________ Date: ______________________________

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

Staff Signature: ______________________________ Print Name: ______________________________