

OpenSided MRI

NAME: _____ DOB _____

ATTENTION: MRI PATIENTS AND ACCOMPANYING FAMILY MEMBERS

Patient safety is our primary concern. The MRI room contains a very strong magnet. Before you are allowed to enter, we must know if you have any metal in your body. Some metal objects can interfere with your scan or even be dangerous, so please answer the following questions **carefully**.

Have you ever had any of the following operations or surgical procedures ? If yes, please explain:

- | | |
|--|---|
| <input type="checkbox"/> Eye surgery | <input type="checkbox"/> Orthopedic surgery |
| <input type="checkbox"/> Ear surgery | <input type="checkbox"/> Vascular surgery |
| <input type="checkbox"/> Heart surgery | <input type="checkbox"/> Back surgery |

Other: _____

Date(s): _____

Yes No Have you ever had any type of cancer? If so, explain _____

Yes No Have you ever been a machinist, welder, or metal-worker?

Yes No Have you ever been hit in the face or eye with a piece of metal?
(including metal shavings, slivers, bullets, or BBs)?

Yes No Have you ever had a piece of metal removed from your eye?

Yes No Are you pregnant, possibly pregnant, or breast feeding?

Date of last menstrual period: _____

DO YOU HAVE ANY OF THESE ITEMS IN YOUR BODY?

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Pacemaker, wires, or defibrillator |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Brain aneurysm clips |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ear implant |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eye implant |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Electrical stimulator for nerves or bone |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Infusion pump |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stents, coil filter, or wires in blood vessels |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Implanted catheter or tube |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial heart valve |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shunt |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Surgical clips, staples, wires, mesh, or sutures |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Orthopedic hardware (plates, screws, pins, rods, wires) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial limb or joint |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Penile prosthesis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Magnetic implant anywhere |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diaphragm or intrauterine device |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | False teeth, retainers, or magnetic braces |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Permanent make-up (eyes, brows, lips) body piercing and tattoos |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bullets, BBs, or pellets |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Metal shrapnel or fragments |

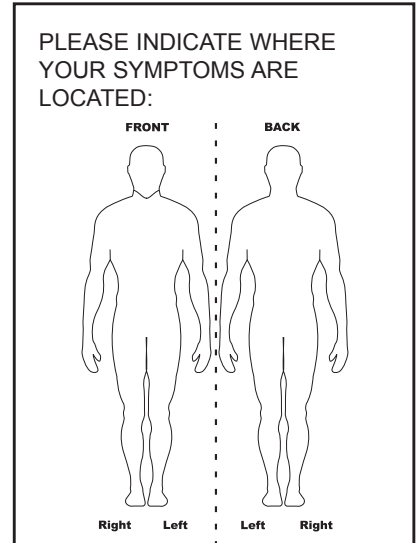
The following items may become damaged or cause injury to others in a strong magnetic field.
THEY MUST NOT BE TAKEN INTO THE MRI SCAN ROOM.

- | | | |
|--------------------|---------------------------------|----------------------------|
| Hearing aid | Jewelry (rings, earrings, etc.) | Pager/cell phone |
| Glasses | Wallet/money clip | Pocketknife |
| Watch | Purse/pocket book | Credit or bank cards |
| Safety pins | Pens/pencils | Artificial limb/prosthesis |
| Hairpins/barrettes | Keys | Dentures/partial plates |
| Wigs/hair pieces | Coins | Retainers |

- Belt buckle
- Bra/girdle/sanitary belt
- Metal zippers/buttons

Patient Symptoms: _____

Were they caused by an accident or injury? _____



I attest that the answers I have provided to the questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature (Patient or Guardian): _____ Date: _____

NOT ALL EXAMS INVOLVE INJECTIONS, ONLY COMPLETE BOTTOM PORTION IF YOU ARE RECEIVING CONTRAST.

Your physician has referred you to us for an MRI examination involving an injection of gadolinium based contrast. This contrast may be beneficial in aiding the radiologist to interpret your images. We are prepared to treat any adverse reaction should it occur. Your physician is aware of the remote possibility of a complication and feels that the diagnostic information obtained far outweighs the minimal risk of the procedure. The percentage of any adverse reaction is <5%.

INFORMED CONSENT FOR INTRAVENOUS CONTRAST INJECTION OF A GADOLINIUM BASED CONTRAST AGENT

For people with severely reduced kidney function, gadolinium contrast is considered a possible cause of a rare disease called nephrogenic systemic fibrosis (NSF). It is suggested that patients who receive hemodialysis treatment for renal failure should schedule their hemodialysis for 2 to 4 hours after gadolinium contrast injection. If you have renal failure but do not need dialysis, please tell the MRI technologist.

Weight _____ lbs

Have you ever had an allergic reaction to any type of contrast? YES _____ NO _____

If yes, please explain

Are you allergic to any medications?

If yes, please explain

Have you ever had any (kidney) renal disease/failure or transplant? YES _____ NO _____

If yes, please explain

Have you ever had any liver disease/failure or transplant? YES _____ NO _____

If yes, please explain

Are you currently on dialysis? YES _____ NO _____

Do you have diabetes? YES _____ NO _____

Do you have a heart condition? YES _____ NO _____

Do you have a history of asthma or emphysema? YES _____ NO _____

Do you have a history of hypertension/high blood pressure? YES _____ NO _____

I attest that the answers I have provided to the questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature (Patient or Guardian): _____ Date: _____

Supervising Technologist _____