

MISSION IMAGING CENTER MRI SCREENING AND CONSENT FORM

Name: _____ Sex: _____ Age: _____ DOB: _____ Weight: _____

Procedure Requested: _____ Symptoms: _____

Please list previous studies you have had of the area we are going to scan (i.e., X-rays, CT, CAT, Ultrasound, Nuclear Medicine, MRI) _____

Please list all surgeries, followed by the date: _____

Screening Questionnaire: This form is approved by the National Safety Council for MRI Screening. We apologize for the length of the questionnaire, but for your safety it is important to complete all of the following questions.

<p>If you are entering the MRI exam room, you need to answer this section.</p> <p>Do you have or have you had any of the following:</p> <p>Yes ___ No ___ Cardiac pacemaker</p> <p>Yes ___ No ___ Brain (intracranial) surgery</p> <p>Yes ___ No ___ Metal entering eye (grinding, fabricating, etc.)</p> <p>Yes ___ No ___ Implanted cardiac defibrillator</p> <p>Yes ___ No ___ Aneurysm clip(s)</p> <p>Yes ___ No ___ Carotid artery vascular clamp</p> <p>Yes ___ No ___ Neurostimulator</p> <p>Yes ___ No ___ Tissue expander. If yes, what type _____</p> <p>Yes ___ No ___ Implanted insulin/infusion pump (drug)</p> <p>Yes ___ No ___ Bone growth/fusion stimulator</p> <p>Yes ___ No ___ Cochlear, otologic, or ear implant</p> <p>Yes ___ No ___ Sensitivity to loud noises</p> <p>Yes ___ No ___ Any type of prosthesis (eye, penile, etc.)</p> <p>Yes ___ No ___ Heart valve prosthesis</p> <p>Yes ___ No ___ Artificial limb or joint</p> <p>Yes ___ No ___ Electrodes (on body, head or brain)</p> <p>Yes ___ No ___ Intravascular stents, filters or coils Placement date: _____ Manufacturer: _____ Model #: _____ Body part: _____</p> <p>Yes ___ No ___ Shunt (spinal, intraventricular, programmable)</p> <p>Yes ___ No ___ Vascular access port and/or catheter</p> <p>Yes ___ No ___ Swan-Ganz catheter</p> <p>Yes ___ No ___ Any implant held in place by a magnet</p> <p>Yes ___ No ___ Transdermal delivery system (must be removed prior to scan)</p> <p>Yes ___ No ___ IUD or diaphragm</p> <p>Yes ___ No ___ Aortic clip</p> <p>Yes ___ No ___ Metal or wire mesh implants</p> <p>Yes ___ No ___ Wire sutures or surgical staples</p> <p>Yes ___ No ___ Harrington rods (spine)</p> <p>Yes ___ No ___ Metal rods in bones</p> <p>Yes ___ No ___ Joint replacement (if yes, where _____)</p> <p>Yes ___ No ___ Bone/joint pin, screw, nail, wire or plate</p> <p>Yes ___ No ___ Hearing aid (remove before MRI)</p> <p>Yes ___ No ___ Dentures (remove before MRI)</p>	<p>If you are the patient you need to answer the following additional questions:</p> <p>Yes ___ No ___ Internal body piercing</p> <p>Yes ___ No ___ Tattooed makeup (eyeliner, lips, etc.)</p> <p>Yes ___ No ___ Body piercing(s)</p> <p>Yes ___ No ___ Any metal fragments</p> <p>Yes ___ No ___ Are you currently breast feeding?</p> <p>Yes ___ No ___ Are you taking any oral contraceptives or receiving hormone treatment?</p> <p>Yes ___ No ___ Do you have any anemia or any diseases that affect your blood, a history of renal disease or seizures? If yes, please describe _____</p> <p>Yes ___ No ___ Are you currently taking or have you recently taken any medication? If yes, please list _____</p> <p>Yes ___ No ___ Do you have any drug allergies? If yes, please list _____</p> <p>Yes ___ No ___ Have you ever had reactions to a contrast medium or dye used for MRI, CT or X-ray procedures? If yes, please describe _____</p> <p>Yes ___ No ___ Have you ever had a personal history of cancer? If yes, please list _____</p> <p>Yes ___ No ___ Breathing disorders</p> <p>Yes ___ No ___ Motion disorders</p> <p>Yes ___ No ___ Claustrophobia</p> <p>Yes ___ No ___ Anxiety</p> <p>Yes ___ No ___ Are you taking any fertility medication or receiving any fertility treatment?</p> <p>Yes ___ No ___ Are you pregnant or experiencing a late menstrual cycle?</p> <p style="text-align: center;">PLEASE COMPLETE DIAGRAM ON NEXT PAGE</p>
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Patient consent for intravenous contrast injection. (Please read and sign below if you are having a contrast examination.) Some MRI exams require the use of intravenous contrast injections. At our facility, we use a contrast called Gadolinium. Gadolinium is a paramagnetic substance that changes the magnetization properties of the tissue that it surrounds. In most cases gadolinium has no effect on the patient. About 1 patient in 3,500 will have a mild reaction such as hives, headaches or nausea. About 1 in one million patients have more severe reactions such as difficulty breathing, swallowing or anaphylaxis. These symptoms can be treated with medication, but death can occur. Your doctor and our radiologist feel that the benefits of the contrast in determining your condition far outweigh the before mentioned risks. If you have any other questions regarding the use of contrast, please ask the technologist prior to your examination.

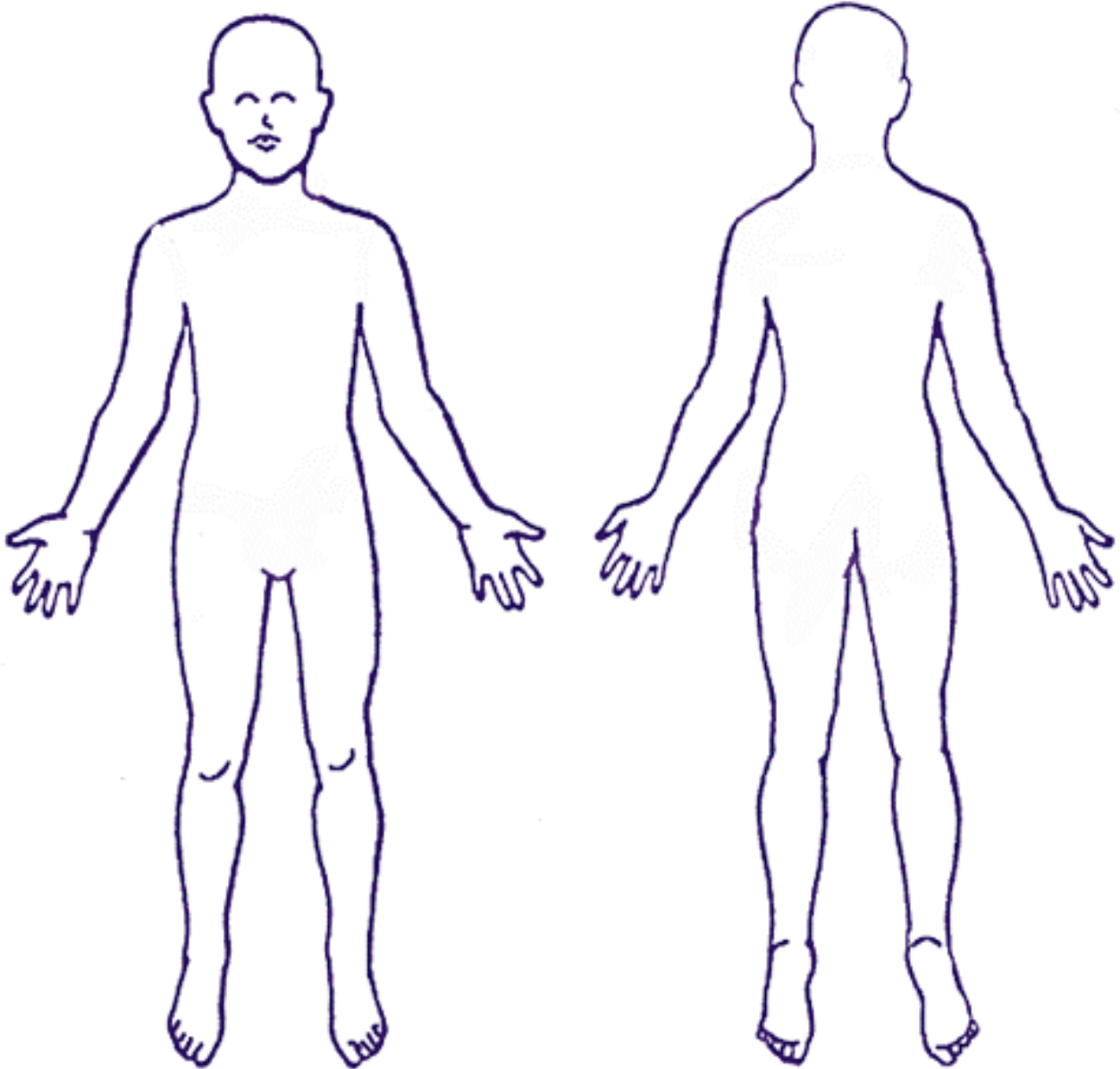
I have read the above information. I wish to proceed with the MRI exam with intravenous contrast.

Patient or Legal Guardian Signature _____ (please state relationship) _____
 Witness _____ Date/time _____

Patient consent to MRI procedure I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form. I also understand that it is important not to bring loose metal objects, such as keys and paperclips, and that I should not bring my watch, purse, credit cards bank cards, beeper, cell phone and any other electronic device into the exam room. I understand that to do so would cause damage to the before mentioned items by the magnetic field. Also, by signing, I give permission to Mission Regional Imaging Center to release the MRI and results of the scan to any doctor that I may see in addition to my referring physician. Images may be sent at the discretion of MRIC electronically, by mail or carrier.

Patient or Legal Guardian Signature _____ (please state relationship) _____ Date _____

Please mark and X on the figures below for the locations of any implants or metal inside your body. In addition, please circle the location of your pain and symptoms.



Technologist's initials _____