



MRI Safety Form

MRI is simple, safe and painless. However, because we use a strong magnet during the procedure, metal objects in your body may be hazardous or cause interference. Please provide us with important information before entering the MRI department.

Name: _____ Age: _____ Weight: _____

Have you ever had an MRI? Yes No Date of Last MRI: _____
 Have you ever had Surgery? Yes No If yes, please list all procedures and dates: _____

Is patient claustrophobic? Yes No
 If yes, patient needs to be pre-medicated and have a driver for the exam.

Do you have any of the following items in or on your body:

- | | |
|--|--|
| Coronary Artery Clip <input type="checkbox"/> Yes <input type="checkbox"/> No | Any Skin Patches <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Implanted Electrical Device <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Ear/Cochlear Implant <input type="checkbox"/> Yes <input type="checkbox"/> No | Neurostimulators <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Brain Aneurysm Clips <input type="checkbox"/> Yes <input type="checkbox"/> No | Stents <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Metal in Eyes-Past or Present <input type="checkbox"/> Yes <input type="checkbox"/> No | Tissue Expander <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial Heart Valves (Need Patient's Card) <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Do you have any history of cancer, past or present? Yes No
 Do you have any allergies to medication or contrast (IVP, Dye, Gadolinium)? Yes No
 If yes, please list _____

Do you have any metal surgically implanted in your body or attached to the outer part of
 Your body (hearing aids, body piercings, prosthetics, hair pins, firearms)? Yes No
 If yes, please list. _____

Female Patients:
 Is there any possibility that you could be pregnant or breast-feeding? Yes No
 Do you have an IUD in place? Yes No

This procedure may require injection of an intravenous contrast material called Gadolinium. This is used to make certain organs visible during your MRI exam. Some, but not all, of the reported side effects, which occur in less than 1% of patients include: nausea, hypotension, vomiting, flushed feeling, pain at injection site, cough, headache, chest pain, itching, hives, seizure, shortness of breath, or rash.

I have read the above information and give my consent to have the MRI examination, and my questions have been answered.

Signed: _____
 Patient/Authorized Person to Consent for Patient

Witnessed: _____

Relationship, If Not Patient: _____

Date: _____ Time: _____ a.m. / p.m.



RADIOLOGY CONSENT FOR USE OF CONTRAST

Your Physician has recommended that you undergo a procedure, commonly known as a CAT scan. This procedure may require the injection of contrast material or x-ray dye. The dye is used for many different exams every day, and there are many different brands of dye, but they all have essentially the same effect and purpose. They are used to make certain organs visible during the x-ray study that you are about to have.

Approximately 50% of patients experience a sensation of warmth throughout the body and a metallic taste in the mouth from the contrast. Other mild reactions that occur in less than 10% of patients and usually require no treatment include: nausea, vomiting, dizziness, coughing, itching and hives. Other reactions may be more severe and require treatment. They are relatively rare and occur in less than 1% of patients. They include difficulty breathing, spasms or fluid in the airways and lungs, kidney failure, cardiac failure, seizures, paralysis, quadriplegia, paraplegia, brain damage and coma. Death from the injection is rare.

A mechanical injector will be used to inject the contrast. With this type of injection, there is the possibility that some of the contrast may infiltrate (leak outside the vein). When there is a significant amount, surgery may be required in order to help minimize any potential problems. Please notify the technologist immediately if you notice a burning sensation or swelling in your arm at the injection site.

Before injection of this contrast material, it is important for the physician and the technologist to know if you have any of the following:

| | YES | NO |
|--|--------------------------|--------------------------|
| Do you have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, are you taking Glucophage, Glucovance, Metformin, Avandament, Riomet, Fortamet, or Metaglip? | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had a reaction to x-ray dye? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what happened? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have thyroid diseases? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have sickle cell anemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have kidney disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have multiple myeloma (a type of cancer)? | <input type="checkbox"/> | <input type="checkbox"/> |
| What medicines or foods are you allergic to? _____ | | |
| Females: Is there any chance you could be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| Date of last menstrual period, if of child bearing age? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever been diagnosed with cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what type and what treatment have you had? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| _____ | | |
| Have you ever had a CAT scan of this area before? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, when and where was it performed? _____ | | |
| Have you had previous surgery in the area being examined? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what type of surgery? _____ | <input type="checkbox"/> | <input type="checkbox"/> |

I have read the above information and give my consent to have this x-ray examination. I state that I was given the opportunity to ask questions about the procedure and all questions were answered in a satisfactory manner.

Signed: _____ Witnessed: _____

Relationship, If Not Patient: _____ Date: _____ Time: _____