MRI Procedure Screen and Consent

PATIENT INFORMATION

Name:	DOB:	Weight:
Body part to be examined:	Ordering Physician:	

Reason for scan (symptoms and/or condition:

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (e.g. MRI, MR angiography, functional MRI, MR spectroscopy). 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 or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on!

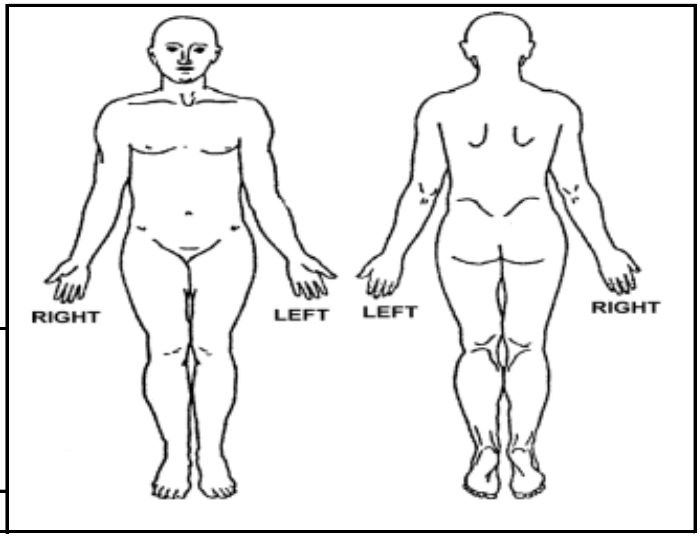
SCREENING

Have you ever had a prior MRI? ☐ Yes ☐ No If "yes" When?_____ Where?_____		
What body party?_____ Did you experience any adverse events or problems related to the MRI?	☐ Yes	☐ No
Have you ever had an injury to your eyes or body involving a metal object or fragment?	☐ Yes	☐ No
Do you have any conditions and/or disease(s) of your heart?	☐ Yes	☐No
If "yes" to above question do you have a cardiac pacemaker, defibrillator (ICD) or coronary stent	☐ Yes	☐ No
Do you have diabetes?	☐ Yes	☐ No
If "yes to above question do you have a continuous glucose monitor (Dexcom, FreeStyle, ect)	☐ Yes	☐No
Do you have any disease(s) of your kidneys or blood?	☐ Yes	☐ No
Do you experience anxiety in closed environments (claustrophobia)?	☐ Yes	☐ No
Have you ever had an allergic reation to contrast ("dye)" during a radiology procedure?	☐ Yes	☐ No
Do you have asthma, respiratory disease or drug allergies?	☐ Yes	☐ No
Are you pregnant or experiencing a late menstrual cycle?	☐ Yes	☐ No
Are you currently breast feeding?	☐ Yes	☐ No

INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

Aneurysm Clip(s)	☐ Yes	☐ No
IUD or internal birth control device	☐ Yes	☐ No
Magnetically activated or electronic implant/device	☐ Yes	☐ No
Any type of shunt, stent or infusion pump	☐ Yes	☐ No
Any type of prosthetic device or artifical limb	☐ Yes	☐ No
Inner ear or cochlear implant	☐ Yes	☐ No
Any neuro, spinal cord or bone growth stimulator	☐ Yes	☐ No
Medication patch on skin	☐ Yes	☐ No
Dentures or removable dental work	☐ Yes	☐ No
Any type of internal or external metallic object	☐ Yes	☐ No
Hearing aids	☐ Yes	☐ No

Please mark on the figures below the location of any implant or metal inside of or on your body



Technologist Notes:

Technologist Signature:

CONSENT

I attest that all the information provided is correct to the best of my knowledge. I have read and understand the entire content of this form and have had the opportunity to address any questions or concerns I have regarding the information pertaining to this form. My signature also indicates that I consent to Zoom Diagnostic Imaging performing any intravenous injection of contrast material that my physician or the radiologist deems necessary. I understand there is a potential risk of mild to severe adverse side effects when receiving this contrast, including a sever anaphylactic allergic reaction requiring medical intervention, the administration of medicines and possible hospitalization. I understand small amounts of contrast may be retained in the body and potentially involve rare conditions such as fibrosis of the skin, muscles, or internal organs. If receiving contrast I have been provided with the opportunity to review a gadolinium medication guide. I understand I have the right to refuse the use of this contrast material.

Patient or guardian signature	Date