

Tesson Heights Orthopaedics & South County Open MRI

MRI PROCEDURE SCREENING AND CONSENT FORM

PATIENT NAME: _____

SEX: _____ PHYSICIAN: _____

DATE OF BIRTH: _____ HEIGHT: _____ WEIGHT: _____

ATTENTION: MRI PATIENTS AND ACCOMPANYING FAMILY MEMBERS-

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.

Yes No Have you ever had an operation or surgical procedure of any kind? Please list all with dates:

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 BB's)?

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

Yes No Are you pregnant or probably pregnant?

RADIOGRAPHS MIGHT HAVE TO BE TAKEN PRIOR TO THIS EXAMINATION.

DO YOU HAVE ANY OF THESE ITEMS IN YOUR BODY?

Yes No Pacemaker, wires or defibrillator

Yes No Brain/aneurysm clip

Yes No Ear Implant

Yes No Electrical stimulator for nerves or bone

QUESTIONS CONTINUED ON NEXT PAGE

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bullets, BB's, pellets, or shrapnel |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hearing Aid |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Nitropatch or other skin patches |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Magnetic implant anywhere |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Infusion Pump |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Coil, filter, wire in blood vessel or stent |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Artificial limp or joint |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Eyelid tattoo |
| <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 | Penile prosthesis |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Shunt |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | False teeth, retainers, magnetic braces, magnetic dentures |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Surgical clips, staples, wires, mesh or sutures |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diaphragm or intrauterine device |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Orthopedic hardware (plates, screws, pins, rods, wires) |

INFORMATION CONCERNING GADOLINIUM CONTRAST MATERIAL

As part of your examination, the MRI radiologist may deem it advisable to give you an intravenous injection of a contrast agent containing Gadolinium. This injection may help the physician more accurately diagnose your condition. Although Gadolinium contrast agents have been used safely in millions of cases, minor reactions (principally headache or nausea) occur in about 2% of patients, whereas serious or life threatening reactions have been reported in about one in 400,000 patients.

- | | | |
|------------------------------|-----------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Have you ever had a previous allergic reaction to Gadolinium contrast material? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have a history of asthma or emphysema? |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Do you have any drug allergies? |

QUESTIONS CONTINUED ON NEXT PAGE

- Yes No Do you have anemia or any other blood diseases?
 Yes No Do you have any kidney problems?
 Yes No Are you breast feeding?

I ATTEST THAT I HAVE FULLY READ AND UNDERSTAND THIS MRI CONSENT FORM AND AGREE TO HAVE THIS EXAMINATION PERFORMED ON ME.

Signature (patient or guardian): _____

MRI Technologist: _____ Date: _____

If patient is unable to consent or is a minor, complete the following:

Patient, _____, (is a minor _____ years of age).

_____	_____	_____
MRI TECHNOLOGIST	RELATIVE/LEGAL GUARDIAN	Relationship

Date: _____

Date: _____