MRI - Part A

Factors such as weight, body shape and scan type may determine if scan can be performed.

Height: _____ Weight: _____ lbs./kg.

Last Name _____

First Name _____

Date of Birth _____ Date _____

Patient safety is our primary concern. The MRI room contains a very strong magnet and is ALWAYS on. Before you are allowed to enter the MRI room, we must know if you have any metal in or on your body. You MUST remove all metallic objects including cell phone, keys, watches, hair pins, pocket knives, lighters, bank cards, purses, wallets, jewelry, etc. Hearing aids must be removed immediately before entering the MRI room. Failure to remove such items can result in serious damage to those items and/or injury to yourself and others. Please answer the following questions carefully.

I have read and understand the above information, and have removed all metal.....☐ Yes ☐ No

Medical/Dental Procedures with sedation in the past 24 hours?.....☐ Yes ☐ No

***** Small Bowel Endoscopy Capsule.....☐ Yes ☐ No**

*****LVAD Device (Heart Pump) .....☐ Yes ☐ No**

*****Breast Tissue Expanders .....☐ Yes ☐ No**

****Existing Pacemaker or Pacemaker wires ☐ Yes ☐ No**

****Implanted Cardiac Defibrillator .....☐ Yes ☐ No**
(past or present)

****Pregnant.....☐ Yes ☐ No**
Last Menstrual Period _____

***Implanted Neurostimulator.....☐ Yes ☐ No**

***Artificial Heart Valves/Heart Stents.....☐ Yes ☐ No**
Date: _____ Make: _____
Model: _____

***Surgical/Vascular Clips/Grafts/Stents.....☐ Yes ☐ No**
Type: _____

***Aneurysm Clips.....☐ Yes ☐ No**

***Recent colonoscopy or digestive system procedure involving surgical clips .....☐ Yes ☐ No**

***Medication Pump.....☐ Yes ☐ No**

***External TENS Unit.....☐ Yes ☐ No**

***Metallic Foreign Body (Gun shot wounds, retinal buckle, etc.).....☐ Yes ☐ No**

***Eye injury involving Metal.....☐ Yes ☐ No**

***Prior Ear, Eye or Brain Surgery.....☐ Yes ☐ No**

***Catheter, Drainage Tube, Temp Monitor.....☐ Yes ☐ No**

Hearing Aids.....☐ Yes ☐ No

Dri Weave, Dri Fit or Wicking Clothing.....☐ Yes ☐ No

Medication Skin Patches.....☐ Yes ☐ No

History of Cancer.....☐ Yes ☐ No
If yes, what type? _____

Joint Replacement/Joint Implants.....☐ Yes ☐ No

Orthopedic or Prosthetic Devices .....☐ Yes ☐ No

Vena Cava Umbrella Filter.....☐ Yes ☐ No

Hair Extensions/Hair Pieces/Wig.....☐ Yes ☐ No

Braces, Oral Springs, Removable Dental Work .....☐ Yes ☐ No

Glitter/Permanent Eye Makeup .....☐ Yes ☐ No

Anything Held with Magnets or Pins.....☐ Yes ☐ No

Tattoos and/or Body Piercing.....☐ Yes ☐ No

Claustrophobic?.....☐ Yes ☐ No

Iron Deficiency being treated w/ Feraheme☐ Yes ☐ No

History of Epilepsy (seizures).....☐ Yes ☐ No

History of Diarrhea in past 2-3 days .....☐ Yes ☐ No

Any falls within past 30 days? .....☐ Yes ☐ No
If yes, when: _____

Anything in or on your body that you weren't born with?
☐ Yes ☐ No If not listed above, notify the Technologist.

Did you pre-medicate for this exam?.....☐ Yes ☐ No
Do you have a driver?.....☐ N/A ☐ Yes ☐ No

Please list all past surgeries and their dates:

_____

_____

Any previous imaging study related to the reason for today's exam?.....☐ Yes ☐ No
Type of Exam _____
Facility _____
Date _____

I have answered the questions above accurately.

Signature of Patient: _____ **Date:** _____ **Time:** _____
(Parent or Guardian if patient is a Minor or Incapacitated) **Relationship:** _____

MRI CANNOT be performed if **"Yes"** is answered to triple asterisked (***) questions. Double asterisked (**) require a signed informed consent. Single asterisked (*) may require further discussion between the Radiologist & Technologist. Document any verbal approvals/instructions on Part B.

I have reviewed each response with the patient or their legal guardian, power of attorney, next of kin, etc. and PERFORMED CLINICAL PAUSE #1.

Technologist's Signature: _____ Date: _____

Revised January, 2019

Attachment A007

ALLIANCE HEALTHCARE | RADIOLOGY

Last Name _____

First Name _____

Date of Birth _____

MRI PRE-CONTRAST SCREENING FOR IV CONTRAST

Your physician or radiologist may deem it necessary for you to have an IV injection of a contrast agent containing gadolinium to improve the quality of your MR examination.

Although gadolinium contrast agents have been used safely in millions of patients, minor reactions (principally headache or nausea), and serious or life threatening reactions may occur.

Have you ever had an injection of contrast before? ☐ Yes ☐ No
Have you ever had a previous reaction to contrast? ☐ Yes ☐ No

If yes, please explain: _____

Are you currently breastfeeding? ☐ Yes ☐ No
Do you have a history of Diabetes? ☐ Yes ☐ No
Do you have Asthma? ☐ Yes ☐ No
Do you have a history of High Blood Pressure? ☐ Yes ☐ No
Are you receiving treatment for Gout? ☐ Yes ☐ No
Do you have a history of breast cancer with lymph nodes removed? ☐ Yes ☐ No
Do you have a history of arterio-venous (AV) fistula? ☐ Yes ☐ No
Do you have a history of Dialysis/Kidney Failure/Renal Insufficiency? ☐ Yes ☐ No

(Tech- If GFR is 30 or less, also utilize Attachment A047- Consent for Gadolinium in Patients with End Stage Renal Disease)

The technologist has explained the procedure to me, I have received and read the medication guide for the gadolinium based contrast agent that may be used as part of my MRI examination and I have had my questions answered.
I agree to have the MRI procedure with injection of contrast if deemed necessary.

_____ _____ _____

Signature of Patient (Parent or Guardian if patient is a minor or incapacitated) **Date** **Time**

Signature of Technologist _____

GFR _____ (Document any contrast protocol modification on Part B)
Creatinine _____ Reference Range_____-_____ Date_____

Contrast Name _____ Amount _____mL Lot # _____
Contrast Expiration Date _____ Contrast NDC # _____
Injection Site _____ Flow Rate _____
Multi-dose vial ☐ or Single-dose vial ☐ ? If single dose vial, amount of discarded contrast _____ mL
IV Device Used _____ Time of Injection_____ Tech Initials _____