MRI Pre-Questionnaire/Contrast Consent

Name:_____ Age:_____ Telephone #:_____

Physician:_____ Weight:_____ Height:_____ Inpatient/Outpatient

Medical Record Number:_____ Exam being performed:_____

Do you have any of the following:

PATIENT TO FILL OUT THIS SECTION					
Pacemaker	**Yes**	**No**	**Cerebral Aneurysm Clip**	**Yes**	**No**
Cochlear Implant	**Yes**	**No**	**Metal in the Eye**	**Yes**	**No**
Neurostimulator	**Yes**	**No**	**Defibrillator**	**Yes**	**No**
IF PATIENT ANSWERED YES TO ANY OF THE ABOVE ITEMS YOU MUST NOT PERFORM THIS EXAM.					
History of renal disease	**Yes**	**No**	**History of diabetes**	**Yes**	**No**
Hypertension	**Yes**	**No**	**Liver Transplant**	**Yes**	**No**
Over 60	**Yes**	**No**	**Renal Transplant**	**Yes**	**No**
Chemotherapy	**Yes**	**No**	**Undergoing Dialysis**	**Yes**	**No**
Sickle Cell Anemia	**Yes**	**No**	**NSF/NFD**	**Yes**	**No**
IF PATIENT ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, PATIENT MUST HAVE CURRENT RENAL FUNCTIONS.					

***Have you had MRI contrast before?** **Yes** **No**

Did you have a reaction? **Yes** **No** **(if yes what was the nature of your response)**

_____

****Have you had prior surgeries?** **Yes** **No** **(if yes please list):**

_____

Do you have any allergies to medications:_____

_____

Do you have any of the following:

Claustrophobia	**Yes**	**No**	**IVC Filter**	**Yes**	**No**
Heart Valve	**Yes**	**No**	**Shrapnel**	**Yes**	**No**
Carotid Clips	**Yes**	**No**	**Infusion Pump**	**Yes**	**No**
Asthma	**Yes**	**No**	**Aortic Clips**	**Yes**	**No**
Harrington Rods	**Yes**	**No**	**Pain Patch**	**Yes**	**No**
Lactating	**Yes**	**No**	**Hearing Aid**	**Yes**	**No**
Are you Pregnant	**Yes**	**No**	**Decorative Tattoos**	**Yes**	**No**
Prosthetics	**Yes**	**No**	**IUD**	**Yes**	**No**
Dentures/Retainers	**Yes**	**No**	**Electrodes**	**Yes**	**No**
Wig/Hairpins	**Yes**	**No**	**Latex allergy**	**Yes**	**No**
Metal in your Body	**Yes**	**No**	**Permanent Cosmetics**	**Yes**	**No**
Injury involving Metal	**Yes**	**No**			
IF THE PATIENT ANSWERED YES TO ANY OF THE ABOVE ITEMS YOU MAY BE REQUIRED TO PERFORM FURTHER EVALUATION					

I attest that the above information is correct to the best of my knowledge and I have had the opportunity to ask questions regarding the information contained in this form. I understand that there is some risk to these procedures with no guaranteed benefits.

Patient Signature:_____ **Date:**_____

Technologist Signature:_____ **Date:**_____

Creatinine:_____ **GFR:**_____

Contrast:_____ **Amount:**_____ **Site:**_____ **Time:**_____ **Tech:**_____

IF RECEIVING CONTRAST:

I understand that side effects can occur due to injection of contrast material for MRI and that severe and even life threatening reactions are possible. The risks have been explained. **I hereby request and authorize performance of the above examination(s) and give my consent for MRI contrast injection. Patient Initial:**_____ **Tech initial:**_____

MEDICATIONS TAKEN AT HOME

Please complete the following:
Include Prescriptions, Over the Counter Meds, Vitamins and Herbals you are presently taking.

Medication	Strength	How Often	Last Taken

EDEMF5123 PNBISOP003 02/22/2017 11:13 NPU7945