



Facility: \_\_\_\_\_

**MRI HISTORY and CONSENT FORM**

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FORM.POL.002  
Effective Date: July 11, 2013

Patient's Name: \_\_\_\_\_ Date of Exam: \_\_\_\_\_

Body Part to be Examined: \_\_\_\_\_ Reason for MRI: \_\_\_\_\_

Referring Dr.: \_\_\_\_\_ Dr. Phone #: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Male  Female If Female, Last Menstrual Period: \_\_\_\_\_ Postmenopausal:  Yes  No

**★ THESE ITEMS CAN INTERFERE WITH MR IMAGING AND SOME CAN BE HAZARDOUS TO YOUR SAFETY. Please check YES or NO for each item.**

Have you ever had: An injury to your eye involving metal?  Yes  No  
 A metallic fragment or foreign body in your head, face, neck or body?  Yes  No  
 If yes to either question above, were you tested to ensure all metal was removed?  Yes  No

SURGICAL IMPLANTS	YES	NO	SURGICAL IMPLANTS	YES	NO
Cardiac Pacemaker . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm Clip . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker Wires . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Neurostimulator . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Electronic Implant or Device . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Implanted Cardiac Defibrillator . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Cord Stimulator . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Bone Fusion or Bone Growth Stimulator . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Cochlear, Otologic or Ear Implant . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Tissue Expander (e.g. breast) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Internal Electrodes or Wires . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Magnetically Activated Implant or Device . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Eyelid Spring or Wire . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Swan-Ganz or Thermodilution Catheter . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Stent . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Clips in Blood Vessel . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Implanted Drug Infusion Device/Pump . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Endoscopy Camera Pill . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Venous Umbrella . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Coil, Filter, Wire in Blood Vessel . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Pessary or Bladder Ring . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Stent in Blood Vessel . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Any Metallic Fragment or Foreign Body . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Shunt (spinal or intraventricular) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Transdermal Medication Patch (Nitro, Nicotine) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Prosthesis (eye, penile, etc) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Bone/Joint Pin, Screw, Nail, Wire, Plate, etc . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Radiation Seeds or Implants . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Harrington Rod (spine) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Limb / Joint Replacement . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Wire Mesh Implant . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Tens Unit . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Surgical Staples, Clips or Metallic Sutures . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Vascular Access Port/Catheter . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Tattoo or Permanent Makeup . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
IUD or Diaphragm . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Dentures or Partial Plates . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Body Piercing Jewelry . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Aid (remove before scan) . . . . .	<input type="checkbox"/>	<input type="checkbox"/>
Motion Disorder . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	Claustrophobia . . . . .	<input type="checkbox"/>	<input type="checkbox"/>

**HEARING PROTECTION**

**★ All patients having MRI studies must wear hearing protection.**

Ear protection is offered in various forms: earplugs, noise reduction headsets, noise cancellation technology.

**CONTRAST CONSENT**

**Due to your medical history, or as requested by your Physician, an injection of MRI Gadolinium Contrast may be necessary to aid the Radiologist in evaluating your MRI Scan.** The Food and Drug Administration has approved this agent. A very small percentage of patients receiving Gadolinium may develop a headache or experience mild nausea. Rarely, local inflammation may occur at the injection site. **Check YES or NO for each item.**

DO YOU HAVE	YES	NO	TECHNOLOGIST NOTES
Kidney Problems . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver Problems . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma or a Respiratory Disease . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes . . . . .	<input type="checkbox"/>	<input type="checkbox"/>	_____

Have you ever had an allergic reaction to MRI contrast?  Yes  No


List all known allergies: \_\_\_\_\_

I CONSENT to having Gadolinium contrast as needed. (Check box if you agree to contrast)  
 I DECLINE having a Gadolinium contrast injection at this time. (Check box if you disagree to contrast)

Patient/Guardian Signature: \_\_\_\_\_ Technologist Signature: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Exam: \_\_\_\_\_

	<p>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 BEFORE entering the MRI exam room.</p> <p><b>The MR system magnet is ALWAYS on.</b></p>
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**PREGNANCY STATUS**

★ It is a recommendation to discontinue breast feeding and discard breast milk for 24 hours after Gadolinium injections.  
**Are you: Pregnant?**  Yes  No    **Possibly Pregnant?**  Yes  No    **Breast Feeding?**  Yes  No

**SKIN WARMING**

★ MRI Radiofrequency has the potential to cause tissue heating. The Technologist will take several precautions to avoid this. **Alert the technologist immediately if you notice any heating sensations during your MRI scan.**

**TATTOOS AND PERMANENT MAKEUP**

★ A small number of patients with tattoos have experienced transient skin irritation, swelling, or heating sensations at the site of the permanent colorings in association with MR procedures. **Individuals with tattoos or permanent makeup should inform the technologist so appropriate precautions can be taken.**

**INJURY / SURGICAL / RADIATION HISTORY**

Did you injure the area of interest?  Yes  No If yes, describe: \_\_\_\_\_

Have you had another exam of the area we are scanning?  Yes  No If yes, describe what/when/where below: \_\_\_\_\_

Have you had surgery or radiation therapy on the area we are scanning?  Yes  No If yes, describe below: \_\_\_\_\_

**CHECK ALL SYMPTOMS RELATED TO THE TYPE OF MRI SCAN YOU ARE HAVING TODAY**

ABDOMEN	BRAIN / IAC	FEMALE PELVIS
<input type="checkbox"/> Abdominal Pain - Describe below: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Loss of Appetite <input type="checkbox"/> Nausea / Vomiting <input type="checkbox"/> Bowel or Bladder Changes <input type="checkbox"/> Weight Loss or Gain	<input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Weakness <input type="checkbox"/> Trouble Walking <input type="checkbox"/> Dizziness <input type="checkbox"/> Speech Problem/Trouble Talking <input type="checkbox"/> Hearing Problem <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Visual Problem <input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Irregular Menstruation <input type="checkbox"/> Painful Menstrual Cycles <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Hysterectomy <input type="checkbox"/> Ovaries Removed
HIP / LEG / KNEE / ANKLE / FOOT	ARM / SHOULDER / ELBOW / WRIST / HAND	<b>SPINE Cervical/Thoracic/Lumbar</b>
<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Locking <input type="checkbox"/> Clicking <input type="checkbox"/> Giving Away <input type="checkbox"/> Swelling <input type="checkbox"/> Numbness <input type="checkbox"/> Weakness <input type="checkbox"/> Lump or Mass <input type="checkbox"/> Pain - Describe below: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Numbness <input type="checkbox"/> Weakness <input type="checkbox"/> Popping <input type="checkbox"/> Grinding <input type="checkbox"/> Swelling <input type="checkbox"/> Lump or Mass <input type="checkbox"/> Pain - Describe Below: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning	<input type="checkbox"/> Back Pain - Describe below: <input type="checkbox"/> Upper <input type="checkbox"/> Middle <input type="checkbox"/> Lower <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Both <input type="checkbox"/> Neck Pain - Describe below: <input type="checkbox"/> Dull <input type="checkbox"/> Sharp <input type="checkbox"/> Both <input type="checkbox"/> Weakness in: <input type="checkbox"/> R Arm <input type="checkbox"/> L Arm <input type="checkbox"/> R Leg <input type="checkbox"/> L Leg <input type="checkbox"/> Pain in: <input type="checkbox"/> R Arm <input type="checkbox"/> L Arm <input type="checkbox"/> R Leg <input type="checkbox"/> L Leg <input type="checkbox"/> Numbness in: <input type="checkbox"/> R Arm <input type="checkbox"/> L Arm <input type="checkbox"/> R Leg <input type="checkbox"/> L Leg
NECK (Soft Tissue)		<b>CHEST</b>
<input type="checkbox"/> Lump or Mass <input type="checkbox"/> Difficulty Swallowing <input type="checkbox"/> Difficulty Talking <input type="checkbox"/> Pain <input type="checkbox"/> Sore Throat		<input type="checkbox"/> Difficulty Breathing <input type="checkbox"/> Chest Tightness / Chest Pain <input type="checkbox"/> Moist Cough <input type="checkbox"/> Dry Cough <input type="checkbox"/> Heart Disease

I attest that the information on this form is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the MR procedure I am about to undergo.

Patient/Guardian Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**FOR STAFF USE:** Screening Performed By:  MR Technologist  Nurse  Radiologist  Other: \_\_\_\_\_

Staff Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_