MRI QUESTIONNAIRE

Name _____ DOB _____ AGE _____
Last First Middle

Sex: M___ F___ Weight_____ Height_____ft_____in. Referring physician: _____

Were you injured? Yes_____ No_____ Is this injury work related? Yes_____ No_____

If yes, date and how?_____

Decribe any symptoms relating to **TODAY'S** exam (aching, burning, pin, and needles, radiating, stabbing, weakness, etc.)

_____

_____

Have you had any of the following (**related to this problem**)? (please mark all that apply)

Surgery_____ Ct Scans_____ Xrays_____ MRIs_____

If yes, when, and where, and the results?_____

_____

Please use back to add additional information

A creatinine blood screening will be done on all patients with the following conditions to assess renal function before injecting contrast. Please answer completely. Do you have any of the following?

Diabetes & Meds _____ Hypertension & Meds _____ Kidney Disease _____ Cancer Treatment _____

Please list all medications: _____

Do you any of the following? (please circle)

Yes No Heart Surgery / Heart Valve / Pacemaker / Defibrilator
Yes No Brain Surgery / Brain Aneurysm Clips If yes, explain:_____
Yes No Injury to eye involving metal or metal shavings
Yes No Have you done any welding?
Yes No Neurostimulator / Biostimulator
Yes No Penis Prosthesis
Yes No History of tumor _____
Yes No Surgery on Spine (neck or back)_____
Yes No Hearing Aids / Ear Surgery / Cochlear Implants
Yes No Any type of Electical / Magnetic or mechanical Implants on or in your body_____
Yes No Implanted Drugs Infusion Pump / Insulin Pump
Yes No Are you pregnant or nursing? Last Menstrual Period?_____
Yes No Gunshot wounds / Shrapnel / BB's
Yes No History of any metallic implant(s), OTHER than dental work, not mentioned/listed above?
If yes, explain:_____
Yes No Will you be seeing a surgeon or specialist?
If yes, when is the next appointment with your doctor or specialist?_____

OFFICE USE ONLY

Time In_____ Time Out_____ Stat Yes No
Exam Ordered:_____ _____ _____
Diagnosis_____
Referring Physician_____
Phone_____
Contrast injected:_____Lot#_____Exp Date:_____ _____
Volume:_____ml Time:_____Injection site:_____
Comments _____
NDC #_____ Tech's Initials_____

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RELATED TO TODAY'S EXAM:

THORACIC / LUMBAR

Yes No Are you having back pain ?
Yes No Does the pain radiate into your legs ?

If Yes, which leg?

Right Left Both

How far down does the pain radiate? _____

How long?: _____

CERVICAL

Yes No Are you having neck pain ?
Yes No Does the pain radiate into your arms ?

If Yes, which arm?

Right Left Both

How far down does the pain radiate? _____

How long?: _____

BRAIN

Yes No Seizures ?
Yes No Dizziness ?
Yes No Blurred Vision ?
Yes No Severe Headaches ?
Yes No Difficulty Hearing ?
Yes No Hearing Loss ?
Yes No Elevated Prolactin Level ?
(prolactin is hormone secreted by the pituitary gland)

Please describe any other problems:

_____

_____

How long?: _____

MUSCULOSKELETAL

Area to be scanned:_____

Please describe any symptoms you may be having:

_____

_____

How long?: _____

Yes No Is this a sport or work related injury ?

If Yes, details:

_____

_____

BREAST

Yes No Implants?
If yes, please circle one: Saline Silicone

Date of last mammogram and where?:

_____

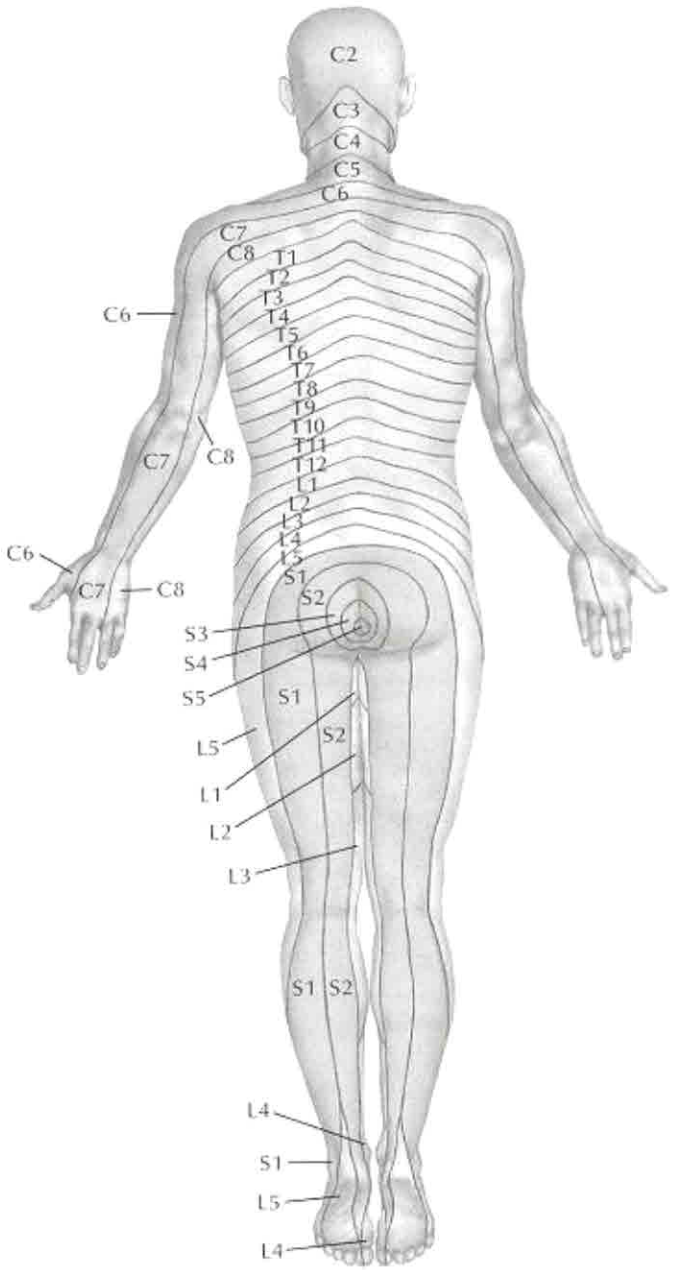
_____

If you are having any problems, please explain:

_____

_____

Please shade the areas where you are experiencing pain, numbness, etc.



MRI PATIENT CONSENT FORM

PATIENT NAME: _____ PATIENT#_____

YOU HAVE THE RIGHT TO BE INFORMED ABOUT YOUR CONDITION AND THE RECOMMENDED DIAGNOSTIC PROCEDURE TO BE USED, SO THAT YOU MAY MAKE THE DECISION WHETHER OR NOT TO UNDERGO THIS PROCEDURE AFTER KNOWING THE RISKS AND HAZARDS INVOLVED. THIS DISCLOSURE IS NOT MEANT TO SCARE OR ALARM YOU. IT IS SO THAT YOU CHOOSE TO GIVE OR WITHOLD YOUR CONSENT TO THE PROCEDURE.

IF YOU ARE PREGNANT OR THINK THAT YOU MIGHT BE PREGNANT, PLEASE INFORM THE CENTER PERSONNEL AT ONCE. IT IS VERY IMPORTANT THAT YOU INFORM THE TECHNOLOGIST IF YOU HAVE HEART VALVES, A PACE MAKER, ANEURYSM CLIPS, OR OTHER IMPLANTED METAL ELECTRICAL DEVICES.

YOUR PHYSICIAN HAS REQUESTED A MAGNETIC RESONANCE IMAGING (MRI) EXAMINATION TO OBTAIN ADDITIONAL INFORMATION. MRI USES A MAGNETIC FIELD, AND RADIO WAVES TO PRODUCE IMAGES OF THE BODY PART BEING EXAMINED. MRI DOES NOT USE X- RAYS OR RADIATION AND IS PAINLESS. SOME SCANNERS MAY PRODUCE LOUD REPETITIVE NOISES THROUGHT THE PROCEDURE. HEADPHONES WILL BE PROVIDED AS NEEDED.

A CONTRAST AGENT (FLUID) MAY BE INJECTED IN YOUR VEIN, AS PART OF YOUR MRI, TO PROVIDE BETTER IMAGES OF THE PART OF THE BODY BEING EXAMINED.

POTENTIAL RISKS: THE FOLLOWING COMPLICATIONS ARE POSSIBLE ANYTIME AN INJECTION IS GIVEN: POTENTIAL FOR PAIN, BLEEDING, BRUSING, OR SWELLING AT THE INJECTION SITE. MRI EXAMS THAT REQUIRE CONTRAST MAY RESULT IN MILD HEADACHE, NAUSEA, ITCHING, OR OTHER VAGUE SYMPTOMS FOR A SHORT TIME AFTER THE INJECTION. ADDITIONAL ALLERGIC REACTIONS IN RESPONSE TO THE CONTRAST AGENT MAY INCLUDE: HIVES, SHORTNESS OF BREATH, OR DIFFICULTY SWALLOWING. THERE HAVE BEEN RARE INSTANCES OF DEATH AFTER THE ADMINISTRATION OF THE CONTRAST AGENT. IT IS VERY IMPORTANT THAT YOU INFORM THE TECHNOLOGIST IF YOU EXPERIENCE ANY OF THE CONDITIONS MENTIONED IN THIS FORM.

IF YOU HAVE PREVIOUSLY HAD A REACTION TO A CONTRAST INJECTION SUCH AS HIVES, SHORTNESS OF BREATH, ANY SIGNIFICANT REACTION REQUIRING HOSPITILIZATION, A HISTORY OF ASTHMA, OR OTHER ALLERGIC CONDITIONS, ANY HISTORY OF ANEMIA, SICKLE CELL ANEMIA, OR KIDNEY DISORDER, OR IF YOU ARE BREAST FEEDING YOU MUST INFORM THE TECHNOLOGIST. THE SAFETY OF CONTRAST IN CHILDREN UNDER 2 YEARS OF AGE HAS NOT BEEN ESTABLISHED.

THERE MAY BE OTHER IMAGING ALTERNATIVES; HOWEVER YOUR PHYSICIAN BELIVES THIS IS THE BEST DIAGNOSTIC TEST FOR YOU, CONSIDERING YOUR SYMPTOMS AND CONDITION. THE BENEFIT OF THIS EXAM IS TO ASSIST YOUR PHYSICIAN WITH A DIAGNOSIS.

I CERTIFY THIS FORM HAS BEEN FULLY EXPLAINED TO ME THAT I HAVE READ IT, OR HAVE HAD IT READTO ME, THAT THE BLANK SPACES HAVE BEEN FILLED IN, AND THAT I UNDERSTAND ITS CONTENTS.

I HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS ABOUT MY CONDITION, ALTERNATIVE FORMS OF TREATMENT/DIAGNOSIS, THE PROCEDURES TO BE USED, AND THE RISKS AND HAZARDS INVOLVED, AND I HAVE SUFFICIENT INFORMATION TO GIVE THIS INFORMED CONSENT.

_____ _____

PATIENT/ PARENT/ LEGAL GUARDIAN SIGNATURE DATE TIME

_____ _____

WITNESS SIGNATURE DATE TIME

Patient Sticker

Pregnancy Release Form

It is recognized that ionizing radiation can be harmful to a fetus or that the effects of a magnetic field has been undetermined as of yet. It is the policy of Imaging Center that women who are pregnant or suspect that they are pregnant should not have an exam that utilizes ionizing radiation or magnetic fields unless the referring physician and/or radiologist determine the exam are medically necessary. Imaging Center requires confirmation of pregnancy/non pregnancy for women of childbearing age prior to performing any radiographic procedure involving ionizing radiation or magnetic field. Childbearing age is considered to be between 10-60 years of age.

PATIENT: Please check and initial your pregnancy status:

- _____I am not pregnant _____(Patients Initials)
- _____I am _____weeks pregnant _____(Patients Initials)
- _____I am unsure of my pregnancy status _____(Patients Initials)

Pregnancy may be confirmed with blood/urine test at the patients' expense. I understand that the urine pregnancy test that the Imaging Center utilizes is not 100% accurate, and if the test is performed within 21 days of conception the results may not be accurate. **If you are pregnant or suspect that you may be pregnant, your options are as follows:**

UNCLEAR PREGNANCY STATUS:

_____I have decided to reschedule the exam/procedure until my pregnancy status is confirmed the Imaging Center personnel will notify my physician of the delay of my exam.

_____I am unsure of my pregnancy status and have decided to decline a pregnancy test. I have decided to have the exam with ionizing radiation and have opted to be shielded. I understand that the shield is not 100% protective against ionizing radiation, and for some procedures requiring images of the pelvis, shielding is not possible.

_____**I have had a pregnancy test and the results indicate**
____I am not pregnant_____(Patients Initials)
____I am pregnant_____(Patients Initials)

POSITIVE PREGNACY STATUS:

At this time **I am pregnant** and I (have):
_____Consented to undergo the exam/procedure_____ (Patients Initials)
_____Decline the exam/procedure _____ (Patients Initials)

By Signing below, I agree that the above statements are true and hereby release the Imaging Center from any complications that may occur from exposure to radiation or a magnetic field and assume responsibility for my decision to undergo the procedure/exam.

_____ _____
Patient/Legal Representative Signature Date/Time

_____ _____
Imaging Center Staff Date/Time

Tech Only: Pt Shielded: YES /NO Tech Initials _____

FORM: RAD1009A
Effective Date:
Revised Date: