



MRI HISTORY AND INFORMED CONSENT

Name: _____ Date: _____ DOB: _____

Sex: _____ Doctor: _____ MRI/MRA of: _____ Weight: _____

What symptoms are you having? _____

How long have you had these symptoms? _____

Are you having pain/weakness/numbness in your: (Circle) Arms Legs Right/Left/Both

Is this due to an injury? Yes/No If yes, Date: _____

Have you had any type of cancer? Yes/No If yes, what type? _____

Have you had surgery to the area being scanned? Yes/No If yes, Date: _____

Have you had any MRI's/CT's of the area being scanned? Yes/No If yes, Date: _____

If yes, Location: _____

Have you worked as a welder, sheet metal worker, or grinder? Yes/No

If yes, have you had an x-ray of the eyes since working with metal? Yes/No

Please check if you have any of the following:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Aneurysm Clips | <input type="checkbox"/> Aortic Clips | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Shrapnel |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Cochlear Implant | <input type="checkbox"/> Brain Surgery | <input type="checkbox"/> Insulin Pump |
| <input type="checkbox"/> Electrodes | <input type="checkbox"/> Fractured Bones | <input type="checkbox"/> Dentures/Partial | <input type="checkbox"/> TENS Unit |
| <input type="checkbox"/> Harrington Rods | <input type="checkbox"/> treated w/metal rods | <input type="checkbox"/> Wire Sutures | <input type="checkbox"/> Hearing Aids |
| <input type="checkbox"/> Prosthesis or Devises | <input type="checkbox"/> Plates, Pins, Screws | <input type="checkbox"/> Inner Ear Pump | <input type="checkbox"/> IUD |
| <input type="checkbox"/> Shunt-Spinal/Ventriple | <input type="checkbox"/> Memory Loss | <input type="checkbox"/> Joint Replacement | <input type="checkbox"/> Medicine Patch |
| <input type="checkbox"/> Electromechanical Device | <input type="checkbox"/> Neurostimulator | <input type="checkbox"/> Metal Mesh Implant | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Hx of renal failure | <input type="checkbox"/> Currently on dialysis | <input type="checkbox"/> Intravascular Coil/Stint | |
| | | Other _____ | |

CONTRAINDICATIONS

Since MRI uses an electromagnetic field, you **cannot** undergo this procedure if you have any of the following:

- | | | |
|-------------------|---------------------------|---------------------------------------|
| Cardiac Pacemaker | Cochlear Implant | Implanted Drug Infusion Pump |
| Neurostimulator | Metal Fragment in the eye | Aneurysm Clips Implanted in the Brain |

****PLEASE INFORM US IF YOU HAVE ANY OTHER IMPLANTS NOT MENTIONED****

Pregnancy

The FDA has not established any criteria under which a pregnant woman may be scanned. It is the policy of this facility that MRI imaging not be routinely performed on women with known or suspected pregnancy.

Contrast

Your doctor may have requested that your exam be performed with intravenous contrast media (gadolinium). Gadolinium injection is FDA approved and indicated for use with MRI exams. Although gadolinium is very safe and allergic reactions are extremely rare, the possibility of allergic reaction does exist. In addition, related complications such as pain or swelling at the site of injection or phlebitis, although rare, are possible. The purpose, benefits and complications of the contrast procedure will be explained to your satisfaction before the injection takes place. Please feel free to express any questions or concerns to the technologist.

I confirm that the information I have provided is complete and accurate to the best of my knowledge. I have read, understand and hereby consent to this MRI examination.

Patient Signature (Parent or Guardian, if patient is a minor)

Date