MEDARVA IMAGING

MRI Patient History and Consent

Patient Name: _____ Date of Exam: _____

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Body Part to be Examined: _____ Male ☐ Female ☐

Referring Physician: _____ Reason for MRI: _____

Date of Last Menstrual Cycle: _____ Postmenopausal: ☐ Yes ☐ No

Have you taken any anxiety or sedation medication today? ☐ Yes ☐ No If yes, what? _____

⚠ **THE ITEMS BELOW CAN INTERFERE WITH MR IMAGING –** SOME CAN BE HAZARDOUS TO YOUR SAFETY

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			Shunt (spinal or intraventricular)		
Electronic Implant or Device			Prosthesis (eye, penile, etc)		
Spinal Cord Stimulator			Radiation Seeds or Implants		
Neurostimulator			Artificial Limb		
Aneurysm Clip			Joint Replacement		
Cochlear/Ear Implant			Port/Catheter		
Internal Electrodes or Wires			Breast Implants		
Cardiac Stent			Breast Tissue Expander		
Artifical Heart Valve			Implanted Device/Pump		
Stent/Coil/Fillter			Medication Patch on skin		
Any Magnetic Implant			Bone/Joint Pin, Screw, Nail, Plate		
IUD			Dentures or Partial Plates		
Body Piercing Jewlery (remove before scan)			Hearing Aid (remove before scan)		
Tattoo or Permanent Makeup			Claustrophobia		

⚠ **HEARING PROTECTION** – All patients having MRI studies MUST wear provided hearing protection, no exceptions.

⚠ Do not enter the MR system room or MR environment if you have any questions or concerns regarding an implant, device, or object. Consult the MRI Technologist BEFORE entering the MRI exam room. The MR system magnet is ALWAYS on.

Pregnancy Status

⚠ If the mother desires, she may refrain from breastfeeding for 24 hours and discard milk 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.**

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Piercings, Cosmetic Implants, Tattoos and Permanent Makeup

⚠ A small number of patients have experienced transient skin irritation, swelling, bruising or heating sensations at the site of piercings, cosmetic implants, tattoos and permanent makeup in association with MR procedures. **Individuals with these items should inform the technologist so 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:

_____

Have you been in the hospital within the last week? ☐Yes ☐No If yes, describe below:

_____

Please list any other surgeries below (include dates):

_____

_____

_____

_____

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: _____ Date: _____

FOR STAFF USE: Screening Performed By: ☐MR Technologist ☐Nurse ☐Radiologist ☐Other: _____

Staff Signature: _____ Date: _____