MRI SAFETY SCREENING QUESTIONNAIRE

PATIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MRN/ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CURRENT WEIGHT: \_\_\_\_\_\_\_\_\_ LBS CURRENT HEIGHT: \_\_\_\_\_\_\_\_\_ FT \_\_\_\_\_\_\_\_\_\_ IN

YES NO

🞎🞎 Cardiac pacemaker or implanted cardioverter defibrillator/ICD

🞎🞎 Internal electrodes or wires

🞎🞎 Artificial heart valve, coil, filter and/or stent (Gianturco coil, IVC filter)

🞎🞎 Aneurysm clip(s), surgical clips, staples or surgical mesh

🞎🞎 Neurostimulator-TENS unit, Biostimulator, bone growth stimulator, DBS, spinal cord stimulator

🞎🞎 Implanted drug pump (chemotherapy, pain medicine)

🞎🞎 External drug pump (insulin or other medicine)

🞎🞎 Implanted post-surgical hardware (pins, rods, screws, plates, wires)

🞎🞎 Artificial eye and/or eyelid spring

🞎🞎 Eye injury from a metal object (metal shavings, metal slivers)

🞎🞎 Ear (cochlear) implant, middle ear implant, hearing aid(s)

🞎🞎 Any type of implant held in place by a magnet

🞎🞎 Injured by a metal object (shrapnel, bullet, BB) and required medical attention

🞎🞎 Medication patch (nitroglycerin, nicotine, contraceptive, estrogen)

🞎🞎 Shunt or Sophy adjustable and programmable pressure valve

🞎🞎 Spinal fixation device, spinal fusion and/or halo vest, spinal cord stimulator

🞎🞎 Tissue expander (breast), Pessary, IUD, Diaphragm

🞎🞎 Are you pregnant or breastfeeding?

🞎🞎 Penile implant

🞎🞎 Body piercing, tattoo or permanent makeup

🞎🞎Implant(s) Model# and Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎🞎 Claustrophobia

🞎🞎 Recent surgery on body part being scanned

If you answered YES to any of the questions, please discuss any concerns and/or issues you may have with the MR technologist or Radiologist.

Instructions for the Patient, Parent, Guardian:

1. Remove ALL jewelry, ALL body piercing jewelry, and ALL hair accessories.
2. Remove dentures, false teeth, partial dental plates, retainers,hearing aids and eyeglasses.
3. Remove ALL clothing expect underwear and change into scrubs provided.
4. Lock your clothes, valuables, and ALL electronics in the locker provided where they will be stored and locked safely during your exam.
5. Please make sure that you receive a pair of earplugs and/or headphones before your MRI exam begins. Some patients may find the noise levels unacceptable, and the noise levels may affect your hearing.

I attest the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

Patient/Parent/Guardian Signature Date

MR Technologist Signature Date/Time

MRI CONTRAST ADMINISTRATION / INFORMED CONSENT

A picture containing text

Description automatically generatedPatient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Procedure Ordered: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your doctor has referred you to our imaging center for a Magnetic Resonance Imaging (MRI) examination requiring an injection of Gadolinium‐Based MRI contrast. Contrast enhances the visualization of tissues to help diagnose a medical condition.

Risks of gadolinium contrast are rare, but may include the following:

* Allergic reaction, nausea, headache, dizziness, metallic taste in mouth, tingling in arm, feeling hot and back pain.
* Insertion of the needle may cause minor pain, bruising and/or infection at the injection site.
* Nephrogenic Systemic Fibrosis (NSF). Patients with severe kidney failure or on dialysis could be at risk for developing NSF, a rare fibrosing condition of the skin and connective tissues which can inhibit your ability to move, adversely affect other organs, and can be potentially life threatening. If you have been diagnosed with kidney failure or are receiving dialysis treatments, please inform the technologist.

Alternatives to Intravenous Contrast: An MRI without contrast or other tests may be possible; however, such procedures may notproduce the same diagnostic result achieved by utilizing intravenous Contrast Agents.

Please answer the following:

YES NO

🞎🞎 Cancer, Type(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎🞎 Kidney disease, Diabetes, and/or on Dialysis? Next treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎🞎 Liver disease

🞎🞎 Allergic reaction to MRI contrast (Gadolinium based), what happened: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*By signing and dating this form, I confirm:*

* I have read and understood the information provided on this form, including the risks described above, including NSF.
* I have received a copy of the Medication Guide, approved by the U.S. Food and Drug Administration, for the gadolinium contrast agent that will be administered.
* I authorize and consent to an MRI with IV gadolinium contrast.

PATIENT SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_

PARENT OR GUARDIAN:(if patient is unable to sign) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MRI STAFF ONLY**

Contrast Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Injection Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount Injected: \_\_\_\_\_\_\_\_\_\_\_\_\_mL Creatinine Value: \_\_\_\_\_\_\_\_mg/dL Date Acquired: \_\_\_\_\_\_ /\_\_\_\_\_\_\_ / \_\_\_\_\_\_

TECHNOLOSIST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_ / \_\_\_\_\_\_ / \_\_\_\_\_\_