inclusive MRI &Diagnostics
12000 RICHMOND AVE. SUITE #125
HOUSTON, TX 77082
281-720-8688 281-720-7225

MR #: _____

MRI AND IV CONTRAST HISTORY AND SCREENING FORM

Patient Name: _____ Date: _____

Sex: **M** **F** Height: _____ Weight: _____ DOB: _____ Age: _____

Referring Physician: _____

Are you pregnant: **YES** **NO** **N/A** Last Menstrual Period: _____

Reason you are here today for an exam:

Explain your medical problem in detail. ***(What happened? Where did it happen? How long have you had this problem?)***

_____

_____

_____

Do you have pain? **YES** **NO** Where? _____

Have you had any surgeries in the area(s) that are being imaged today? **YES** **NO** Where: _____

Have you taken any medication/sedation/alcohol today to help you relax for this procedure? **YES** **NO**

If yes, please list: _____time taken: _____

Have you had a previous exam related to this problem? **YES or NO** If yes, explain: _____

_____

Do you have any of the following? **(circle, if yes, please explain)**

Yes **No** Heart Surgery/Heart Valve _____

Yes **No** Brain Surgery/Brain Aneurysm Clips _____

Yes **No** Shunts/Stents/Intravascular Coil _____

Yes **No** Eye Surgery/Implants_____

Yes **No** Injury to eye involving metal or metal shavings _____

Yes **No** Penile Prosthesis _____

Yes **No** Orthopedic Pins/Rods/Screws/Plates/etc. _____

Yes **No** Neurostimulator/Biostimulator_____

Yes **No** Radiation Therapy/Chemo Therapy_____

Yes **No** History of Cancer or Tumor_____

Yes **No** Surgery on spine (Neck or Back) _____

Yes **No** Hearing Aids/Ear Surgery/Cochlear Implants_____

Yes **No** Vascular Access Ports _____

Yes **No** IUD/Diaphragm/Pessary_____

Yes **No** Metal/Mesh Implants/Wire Sutures/ Staples/Internal Electrodes _____

Yes **No** Any type of Electrical/Magnetic/Mechanical Implants in your body _____

Yes **No** Implanted Cardiac Pacemaker or Defibrillator_____

Yes **No** Pacing Wires/Swan-Ganz Catheter _____

Yes **No** Are you pregnant? Last Menstrual Period _____

Yes **No** Tattoos/Permanent Make-up/ Body Piercings, Hair Extensions _____

Yes **No** Dentures/Partials/Dental Implants_____

Yes **No** Gunshot Wounds/ Shrapnel/ BB's _____

Yes **No** Seizures/Headaches/Dizziness _____

Yes **No** Asthma/Allergic Respiratory Disease _____

Yes **No** Blood disorder/ Sickle Cell Anemia _____

Yes **No** Are you breast feeding at this time? _____

Yes **No** Have you ever had a reaction to MRI contrast in the past? _____

Yes **No** Stroke _____

Yes **No** Kidney Disease _____

Yes **No** Liver Disorder _____

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List any drug allergies: _____

List all surgeries in your lifetime: _____

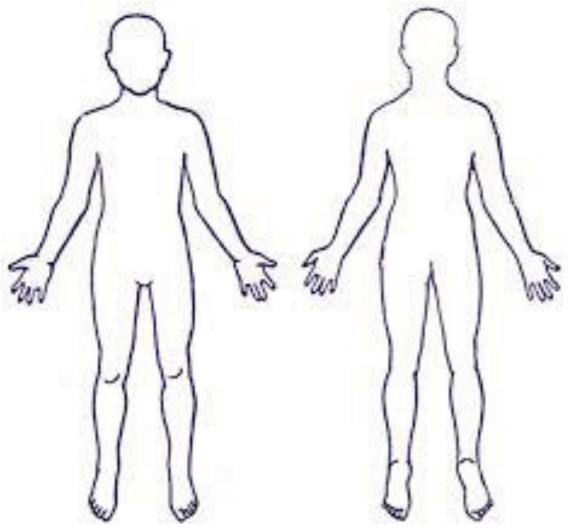
_____

List all medications you are currently taking: _____

_____

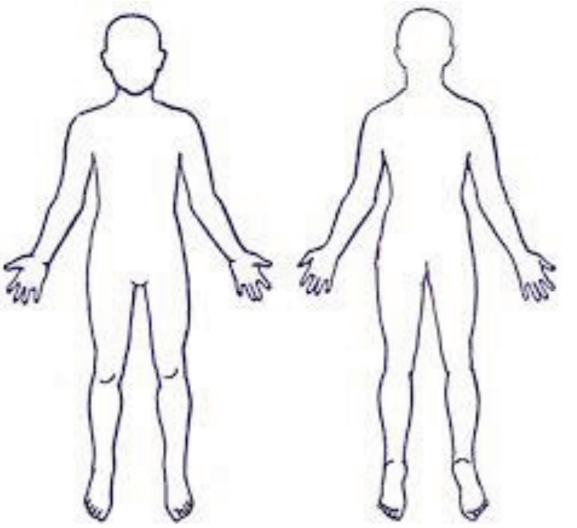
_____

Draw where your pain or symptoms are located on the figure below:



FRONT BACK

Draw the location of any metal in your body on the figure below:



FRONT BACK

Acknowledgement: I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that at this time I am **pregnant OR NOT pregnant** (circle)**.**

_____ _____ _____

Patient/Parent/Legal Guardian Signature Technologist Date

********** ***For Clinicians Use Only*** **********

BUN: _____ Creatinine: _____ or **N/A**

Patient Pre-Exam Education Given: **YES** **NO**

Clinician Providing Contrast Coverage: _____

Contrast Administration:

_____cc of _____with a _____ @_____×_____

(Needle Gauge & Type) (Time) (Number of Punctures)

By: _____ in _____

Clinician Signature Location of Site

Lot #: _____ Expiration Date: _____

Contrast Reaction: **YES** **NO**

Patient Discharge Instruction Given: **YES** **NO**

Discharge Instruction for Contrast Extravasation Given: **YES** **NO** **N/A**

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Magnetic Resonance Imaging (MRI) Consent Form

You have the right to be informed about 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 can choose to give or withhold your consent to the procedure.

If you are pregnant or think you may be pregnant, please inform center personnel at once. It is very important that you inform the technologist if you have a heart valve, a pacemaker, aneurysm clips, or other implanted metal or 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 throughout the procedure therefore, headphones or earplugs will be provided.

A contrast may be injected 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, bruising or swelling at the injection site. MRI exams requiring 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 in 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 hospitalization, a history of asthma or other allergic conditions, any history of anemia, sickle cell anemia or kidney disorder; or if you are breastfeeding you must inform the technologist. The safety of contrast in children under 2 has not been established.

The diagnostic test being performed was ordered by your physician based on your symptoms and condition. The benefits of this exam are to assist your physician with a diagnosis.

In conjunction with the American College of Radiology (ACR) guidelines, it is the policy of to identify patients at risk of developing Nephrogenic Systemic Fibrosis (NSF) prior to any Gadolinium-Based Contrast Agent (GBCA) injection. The method used to identify such patients require assessing renal function at the time of service. Using a point of service device, a serum creatinine level is acquired and used to calculate current estimated Glomerular Filtration Rate (eGFR). If provided, you and/or your insurance company will be billed for this service.

I (WE) CERTIFY THIS FORM HAS BEEN FULLY EXPLAINED TO ME, THAT I (WE) HAVE READ IT, OR HAVE HAD IT READ TO ME (US), THAT THE BLANK SPACES HAVE BEEN FILLED IN AND THAT I (WE) UNDERSTAND ITS CONTENTS. I (WE) HAVE SUFFICIENT INFORMATION REGARDING THE PROCEDURE(S) AND THE RISKS AND HAZARDS INVOLVED.

Patient Name Printed: _____

Patient Signature: _____

Date: _____Time: _____: _____ AM or PM

Witness Name Printed: _____

Witness Signature: _____

Date: _____Time: _____: _____ AM or PM