Elevation Medical
IMAGING

MRI Screening Form

Patient Name: _____

Age: _____ Height: _____ Weight: _____

Patient History

- Reason for Exam: _____
- Have you ever had surgery on the area being scanned? YES NO
  - If yes, what type of surgery: _____
    Date of surgery: _____
- Have you had any prior imaging of the area being scanned? YES NO
  - If yes, what type of exam: _____
    Location exam was done: _____ Date of exam: _____
- Have you ever had an eye injury involving metal? (Grinding, fabrication, etc.) YES NO
  - If yes, please describe: _____
- Do you have an implanted cardiac pacemaker or defibrillator? YES NO
- Do you have a arm glucose monitor device? YES NO
- Are you pregnant and/or breastfeeding? YES NO

WARNING: Some of the following items may be extremely hazardous to your safety and interfere with the MRI exam. **Please circle YES or NO if you have the following.**

YES	NO	Claustrophobia	YES	NO	Tattooed Eyeliner or Eyebrows
YES	NO	Aneurysm Clip or Brain Clip	YES	NO	Transdermal medicine patches (smoking, pain, etc.)
YES	NO	Carotid Artery Vascular Clamp	YES	NO	Internal Pacing Wires
YES	NO	IUD, Diaphragm, Pessary, or Bladder Ring	YES	NO	Aortic Clips
YES	NO	Spinal Fusion Stimulator	YES	NO	Metal or Wire Mesh
YES	NO	Insulin or Infusion Pump	YES	NO	Screws, Pins, or Nails in the Bone
YES	NO	Electronic or Implanted Device	YES	NO	Dentures or Partial Plates
YES	NO	Prosthesis (eye, penile, etc.)	YES	NO	Cochlear Implant
YES	NO	Magnetic Implant (dental, etc.)	YES	NO	Internal Electrodes or Wires
YES	NO	Heart Valve Replacement	YES	NO	External Fixators
YES	NO	Artificial Limb or Joint	YES	NO	Tissue Expander (e.g., breast)
YES	NO	Hearing Aids	YES	NO	Radiation Seeds or Implants
YES	NO	Intravascular stents, filters, or coils	YES	NO	Bone Growth Stimulator
YES	NO	Shunt (spinal or intraventricular)	YES	NO	History of Stroke
YES	NO	Ports or Catheters	YES	NO	Asthma or Breathing Disorder
YES	NO	Endoscopic Clips	YES	NO	Seizures or Motion Disorders
YES	NO	Body Piercing Jewelry	YES	NO	Any other metallic fragment or foreign body

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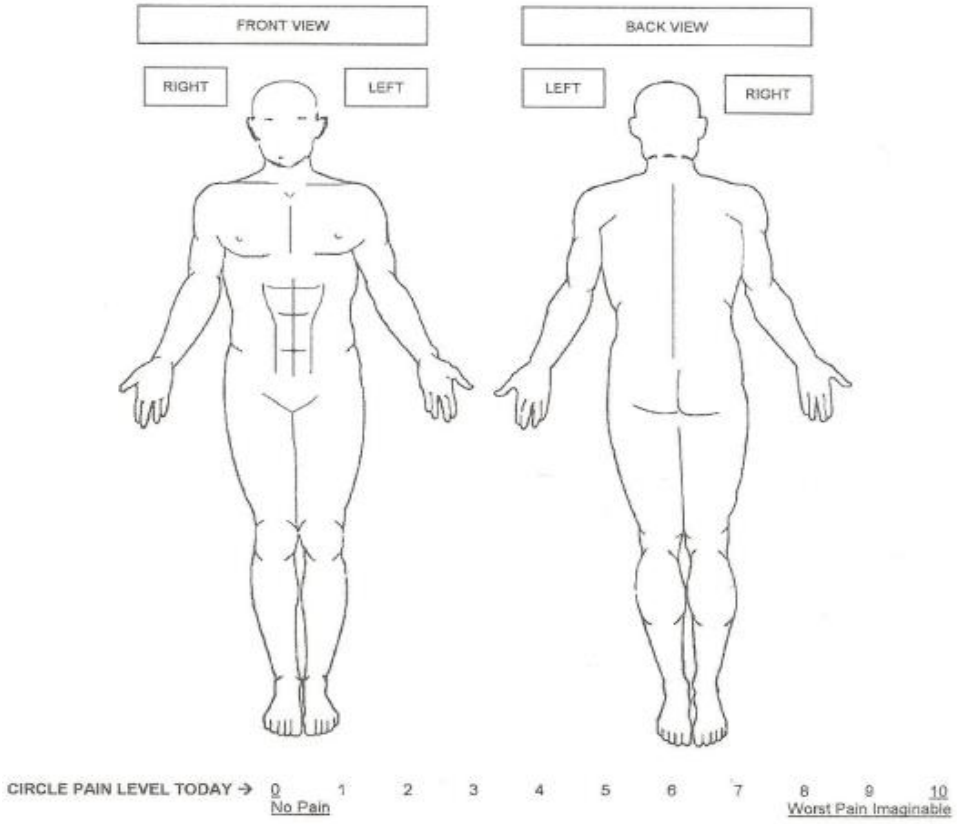
Please mark the area(s) of pain on the diagram below.



IMPORTANT INSTRUCTIONS: Remove all metallic clothing and objects before entering MRI including hearing aids, cell phone, keys, glasses, hair pins/barrettes, jewelry, watch, safety pins, money clips, credit/bank cards, and coins. Loose metallic objects are especially prohibited in the MRI environment.

Please consult the MRI Technologist if you have any questions or concerns BEFORE your scan.

I attest that the above information is correct, to the best of my knowledge, and agree to have this MRI procedure.

Patient/Legal Guardian: _____ Date: _____

MRI Technologist: _____ Date: _____

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MRI IV Contrast Consent Form

As part of your MRI examination, you will be given a prescribed amount of contrast material. Contrast is injected through an IV into a vein and is imaged with MRI. Studies show that contrast material is considered safe, there are occasional side effects and reactions. Some of the reactions may include:

- **Minor reactions:** such as itchy hives or nausea.
- **Serious reactions:** shortness of breath, irregular heart rhythm, convulsions, kidney failure, or unconsciousness. These side effects may require immediate medical intervention.
- **Death:** this occurs rarely but is possible as with many drugs.

- Do you have contrast allergy or allergy to MRI contrast? YES NO
- Have you ever been given an MRI contrast agent through an IV? YES NO
- Did you have a minor or serious reaction to the contrast? YES NO
    - If yes, was your reaction minor or serious? MINOR SERIOUS

- Have you ever had any kind of cancer? YES NO
- Do you have diabetes or kidney disease? YES NO

By signing below, you are confirming that you have been **informed of the risks** and benefits of using IV contrast media for a radiological examination. You are authorizing Elevation Medical Imaging to administer the appropriate IV contrast required for your radiological examination and **you authorize any appropriate care or intervention** that may be required in conjunction with the specified MRI IV contrast media **in the event of any adverse reactions.**

If you develop symptoms of an adverse reaction after leaving Elevation Medical Imaging, please seek care from your ordering physician or local emergency room.

_____ _____

Patient Signature (Unless Patient is minor or unable to sign) Date

_____ _____

Parent/Guardian/Legal Power of Attorney Date

For Staff Use Only:

Creatinine: _____ GFR: _____ Date: _____

IV Site/Gauge: _____ Rate: _____ Contrast Volume: _____ [Place contrast sticker here]

IV DC'D with Catheter Intact: YES NO

Complications: _____

On-Site Physician: _____

Consenting & Administering Technologist(s): _____ Date/Time: _____