



## ADVANCED DIAGNOSTICS & AFFILIATES

Open MRI, Stand-Up MRI, 64 Slice CT, Nuc Med, Ultrasound, & X-Ray

### MRI SAFETY WORK-UP

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Last) (First) (M.I.)

Weight: \_\_\_\_\_ M/F Ordering Physician: \_\_\_\_\_

Have you had an MRI Scan before? YES/NO If Yes, Where? \_\_\_\_\_

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

**Cardiac Pacemaker** YES/NO (If YES, stop paperwork and bring to front desk.)

#### YES NO

- \_\_\_\_ Wires or Implanted Defibrillator  
\_\_\_\_ Brain or Aneurysm Surgical Clips  
\_\_\_\_ Any Electronic, Magnetic or Mechanically activated implant or device  
\_\_\_\_ Have you ever had a metallic object in the eye, or removed from the eye?  
(Metal shavings, Slivers, Welding Fragment, etc.)  
\_\_\_\_ Brain or Heart Surgery \_\_\_\_\_  
\_\_\_\_ Any Vascular Clip, filter or Shunt  
\_\_\_\_ Ear Implant, Stapes or cochlear Implant \_\_\_\_\_  
\_\_\_\_ Eye Implant or Prosthesis \_\_\_\_\_  
\_\_\_\_ Joint Replacement, Screws, Pins, Bone Clips \_\_\_\_\_  
\_\_\_\_ TENS Unit, Insulin Pump, Implanted Medicinal Delivery Unit  
\_\_\_\_ Shrapnel, Bullets, BB's  
\_\_\_\_ Hearing Aid  
\_\_\_\_ Dental Implant with Magnetic Fasteners  
\_\_\_\_ Dentures, Partial Plate, Permanent Bridge  
\_\_\_\_ Have you had surgery in the past 6 weeks? Describe: \_\_\_\_\_  
\_\_\_\_ Have you had surgery on the body part to be scanned? \_\_\_\_\_  
\_\_\_\_ Have you ever been diagnosed with Cancer, or a Tumor? \_\_\_\_\_  
\_\_\_\_ Diabetes, or other Kidney Disease? \_\_\_\_\_  
\_\_\_\_ Do you have a history of Asthma, or other allergic respiratory disorder?  
\_\_\_\_ Do you have Anemia, or disease of the Red Blood Cells? \_\_\_\_\_  
\_\_\_\_ Female: Are you Pregnant? Date of last menstrual cycle: \_\_\_\_\_  
\_\_\_\_ Are you nursing?  
\_\_\_\_ Do you have an IUD or Contraceptive Diaphragm? \_\_\_\_\_  
\_\_\_\_ Previous complication to MRI, or MRI contrast? \_\_\_\_\_

#### Please remove the following items before entering the MRI scan room...

- |                   |                       |                                   |
|-------------------|-----------------------|-----------------------------------|
| Hearing Aid       | Belt buckle           | Bra/girdle/sanitary belt          |
| Wallet/Money clip | Artificial limb       | Jewelry Watch                     |
| Credit or bank    | Safety pins           | Wigs/hair pieces                  |
| Glasses           | Metal zippers/buttons | Dentures/partial plates/retainers |

I attest that the answers I have provided to the questions on this form are correct to the best of my knowledge. I understand that the Center is not responsible for valuables and personal property brought to the facility. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature (patient or guardian) \_\_\_\_\_ Date: \_\_\_\_\_

Technologist's initials or signature \_\_\_\_\_



Health History Questionnaire for Patients Receiving Gadolinium

Warning! If you have impaired kidney function, require kidney dialysis, or have a personal history of kidney disease, please notify a staff member IMMEDIATELY!

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Examination Type: \_\_\_\_\_ Examination Date: \_\_\_\_\_

**YES NO**

\_\_\_\_\_ Do you have any allergies? Please list:

\_\_\_\_\_ Are you or could you possibly be pregnant?

\_\_\_\_\_ Are you breast-feeding?

**Breast milk should be discarded for 48 hours after injection.**

\_\_\_\_\_ Have you ever had a previous allergic reaction to MRI contrast?

\_\_\_\_\_ Do you have serious allergies (not minor seasonal allergies)?

\_\_\_\_\_ Do you have asthma?

\_\_\_\_\_ Do you have hemolytic anemia?

\_\_\_\_\_ Do you have sickle cell disease?

\_\_\_\_\_ Do you have a history of kidney disease?

\_\_\_\_\_ Do you have poorly controlled hypertension?  
(Greater than 180/110 mm HG)

\_\_\_\_\_ Do you have cardiomyopathy or congestive heart failure?

\_\_\_\_\_ Do you have diabetes?

\_\_\_\_\_ Are you currently taking any medication containing metformin?

This includes the Metformin (generic), Avandamet, Glucophage XR, Glucovance, and Metaglip

I attest that the above information is correct to the best of my knowledge. I have read and understand the information on this form and the procedure I am about to undergo.

**Signature of Person Completing Form:**

\_\_\_\_\_ Date: \_\_\_\_\_

**Signature of the MRI Technologist:**

\_\_\_\_\_ Date: \_\_\_\_\_



## **Informed Consent for Gadolinium Administration**

As part of your scheduled MRI examination, you will receive an intravenous injection of gadolinium, a contrast agent that will provide additional diagnostic information for your physician.

A saline solution will drip through the intravenous line to prevent clotting until the contrast material is injected at some point during the exam. Unlike contrast agents used in x-ray studies, MRI contrast agents do not contain iodine and therefore only rarely cause allergic reactions or other problems. If you have a history of kidney failure and are scheduled to undergo a procedure which requires gadolinium, you may be at risk for a rare condition known as Nephrogenic Systemic Fibrosis or Nephrogenic Fibrosing Dermopathy (NSF/NFD). NSF/NFD may result in damage to body organs and possible death.

Although gadolinium has been found to be a very safe contrast agent, there is always the risk of a reaction. These reactions can range from minor ones such as nausea, warmth at the injection site, headache dizziness, itching, flushing, and hives to more severe reactions such as cardiac arrhythmias, shortness of breath, wheezing, convulsions, unresponsiveness, or even death. These life-threatening reactions are exceedingly rare, occurring in only 0.01% - 0.001% of cases. The medical personnel in charge of your exam are prepared and trained to respond to these types of reactions.

Alternatives to using intravenous contrast are available. These procedures may be able to provide the necessary diagnostics information. Please ask to speak with the technologist or supervising physician should you have any questions regarding an alternative imaging procedure.

By signing this document, you agree that you have read this form, understand the information above, and have had any questions answered. In addition, you agree that you: 1) have been informed of the purpose of using the contrast agent, 2) understand the risks, benefits, and possible complications associated with the contrast agent, 3) are aware of possible alternatives to the contrast agent and 4) have been given the right to refuse to consent to the procedure.

**I HAVE READ AND UNDERSTAND THE ABOVE AND GIVE MY CONSENT TO HAVE THE CONTRAST ADMINISTERED.**

Patient or Legal Representative Name (Print)

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Signature

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Date: \_\_\_\_\_