MRI Questionnaire
(without Contrast)

Date of follow up appointment with your Dr.: _____

Please note it can take up to 72 hours before your Doctor receives your MRI report

Weight: _____ Height: _____

Reason doctor ordered MRI (describe any pan or symtoms): _____

_____

Any prior imaging of the area to be scanned today? Y/N (if YES, when and where were they performed?)_____

Any prior surgeries on the area being scanned today? Y/N (if YES, please list):_____

Personal history of Cancer? Y/N (if YES, please explain):

Please indicate if you have any of the following:

Yes☐ No☐ Cardiac Pacemaker or pacemaker wires	Yes☐ No☐ Medication Patch
Yes☐ No☐ Implanted Cardiac Defibrillator	Yes☐ No☐ IUD, diaphragm or pessary
Yes☐ No☐ Brain Aneurysm Clips/Coils/Brain surgery	Yes☐ No☐ Penile implant
Yes☐ No☐ Neurostimulator / Spinal Cord Stimulator	Yes☐ No☐ Injury to eye involving metal/metal shavings
Yes☐ No☐ Heart surgery/Heart valve	Yes☐ No☐ Gunshot wounds/shrapnel/BB
Yes☐ No☐ Shunts/Stents/Filters/Coils	Yes☐ No☐ Tattoos/Permanent Make-up/Magnetic Eyelashes
Yes☐ No☐ Eye surgery/Implants/Retinal tack/Eyespring/Wire	Yes☐ No☐ Body piercing (Including ears)
Yes☐ No☐ Ear surgery/Cochlear/Stapes/Ear Implant	Yes☐ No☐ Dentures/partials/dental implants/braces
Yes☐ No☐ Vascular Access/Port Catheter	Yes☐ No☐ Pins in hair/clothes/hair extensions/wig
Yes☐ No☐ Orthopedic Pins/rods/screws/prosthesis	Yes☐ No☐ Hearing Aids
Yes☐ No☐ Radiation seeds or implants	Yes☐ No☐ Pregnant or Breastfeeding
Yes☐ No☐ Implanted drug pump/Insulin Pump	Yes☐ No☐ Breast tissue expander

Please explain any items you marked **YES above:**

_____

_____

Your signature below indicates that all the information above is accurate, you have read and understand the above information, all of your questions have been answered and you consent to the procedure(s).

_____ _____

Patient/Guardian Signature **Date**

IMPORTANT INSTRUCTIONS:
Before entering the MRI room, you must remove all metallic objects including cell phones, jewelry, eye glasses, hair pins, barrettes, watch, credit cards, bank cards, magnetic strip cards, pens, pocket knife, etc. You will be given a locker to secure your belongings in. Please lock the door and take the key with you.

Technologist Use Only:

Tech:	**FILM/CD:**
Notes:	

MRI Questionnaire (with Contrast)

Date of follow up appointment with your Dr.:_____

Please note it can take up to 72 hours before your Doctor receives your MRI report **Weight:** _____ **Height:**_____

Reason doctor ordered MRI (describe any pain or symtoms): :_____

_____

Any prior imaging of the area to be scanned today? Y/N (if **YES**, when and where were they performed?)_____

Any prior surgeries on the area being scanned today? Y/N (if **YES**, please list):_____

Personal history of Cancer? Y/N (if **YES**, please explain):_____

Please indicate if you have any of the following:

Yes☐ No☐ Cardiac Pacemaker or pacemaker wires	**Yes☐ No☐** Medication Patch
Yes☐ No☐ Implanted Cardiac Defibrillator	**Yes☐ No☐** IUD, diaphragm or pessary
Yes☐ No☐ Brain Aneurysm Clips/Coils/Brain surgery	**Yes☐ No☐** Penile implant
Yes☐ No☐ Neurostimulator / Spinal Cord Stimulator	**Yes☐ No☐** Injury to eye involving metal/metal shavings
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Yes☐ No☐ Orthopedic Pins/rods/screws/prosthesis	**Yes☐ No☐** Hearing Aids
Yes☐ No☐ Radiation seeds or implants	**Yes☐ No☐** Pregnant or Breastfeeding
Yes☐ No☐ Implanted drug pump/Insulin Pump	**Yes☐ No☐** Breast tissue expander

Please explain any items you marked **YES above:** _____

Please list any allergies:_____
Have you ever received an injection of MRI contrast in the past? Y/N
Have you had a prior allergic reaction to gadolinium (MRI contrast)? Y/N
(If YES, please explain):_____

Yes☐ No☐ History of diabetes	**Yes☐ No☐** History of liver disease or liver transplant
Yes☐ No☐ History of hypertension	**Yes☐ No☐** History of kidney disease, kidney failure, or are you on dialysis?
	Yes☐ No☐ History of bloodborne diseases, HIV, HepC, HepB

Your signature below indicates that all the information above is accurate, you have read and understand the above information, all of your questions have been answered and you consent to the procedure(s).

MRI CONTRAST CONSENT

Your physician had determined that an MRI study with gadolinium is needed to help diagnose your medical condition. Gadolinium contrast is given by injection into a vein and aids in distinguishing normal from abnormal tissues.

The gadolinium contrast agent you will recieve has been approved as safe and effective by the U.S. Food and Drug Administration (FDA). As with any medication, a small chance exists that you may have a reaction to it.

Any injection carries with it the risk of damage to a vein, artery, nerve or skin, risk of infection and risk of allergic reaction. Many patients receiving gadolinium may experience a momentary cold feeling in the area of injection. On very few occasions, a patient may experience an allergic reaction to gadolinium. The most common of the reactions are pain at the injection site, nausea, headache, dizziness, itching, rash, hives or temporary breathing difficulty.

The use of gadolinium contrast is optional. However, your physician believes the potential diagnostic benefits for you exceed these small risks. By signing below you understand the statements above and agree to receive gadolinium contrast for your exam.

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Patient/Guardian Signature: _____ **Date:** _____

Technologist Use Only:

Tech:	**FILM/CD:**
Contrast:	**Creatine/BUN:**
ML/Lot #:	**Notes:**