

PATIENT NAME _____ DATE _____ WEIGHT/HEIGHT _____

Which body part are we scanning? Why? _____ DOB _____

! WARNING ! IF YOU HAVE A PACEMAKER/DEFIBRILLATOR, ANEURYSM CLIP, OR NEUROSTIMULATOR, DO NOT PROCEED WITH YOUR SCAN. PLEASE NOTIFY A STAFF MEMBER, IMMEDIATELY!

Do you have any of the following items?

Indicate by circling Yes or No.

Yes No Pacemaker/Defibrillator
 Yes No Aneurysm clips
 Yes No Electrical stimulators for nerves or bone
 Yes No Internal pacemaker or stimulator wiring
 Yes No Implanted heart valve brand/model _____
 Yes No Claustrophobia
 Yes No Metal fragments in the eye (may need x-ray)
 Yes No Intravascular stent or coils type _____
 Yes No Infusion pumps for morphine or insulin
 Yes No IVC filter brand/model _____
 Yes No IUD birth control device brand _____
 Yes No Bullets, BB's, pellets, or shrapnel
 Yes No Eye or Ear implants
 Yes No Programmable Shunt
 Yes No Pregnancy or breastfeeding
 Yes No Surgically implanted metal
 Yes No Tattoos, tattoo eye or lip liner
 Yes No History of Cancer type _____
 Yes No Taking Feraheme iron replacement therapy
 Yes No Camera capsule

If you respond "yes" to any of the items below, they must be removed before entering the MRI room!

Yes No Insulin pump
 Yes No Hearing aids
 Yes No Medicine patches (smoking, estrogen, nitro)
 Yes No Dentures, partials (remove for Brain MRI)
 Yes No Artificial limb
 Yes No Body piercings
 Yes No Hair pins, clips, or wigs
 Yes No Jewelry, necklace, watches
 Yes No Wallet, purse, credit (ATM) cards, coins
 Yes No Loose metallic/electronic objects (cell phone, pagers, pocket knife, keys.)

If you have **any medical implants** or **prior surgeries**, please explain here in the space provided: _____

If your exam is ordered with gadolinium contrast, please answer the following questions.

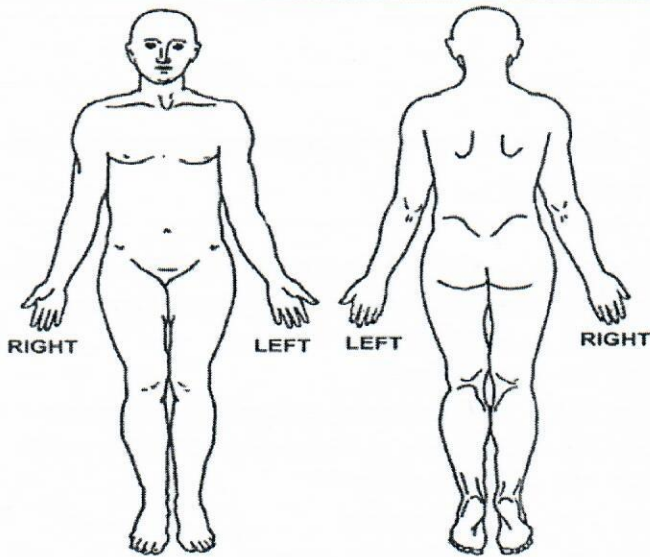
Yes No Are you allergic to MRI contrast dye?
 Yes No Do you have diabetes? (Inpatients)
 Yes No Do you have impaired renal (kidney) function, including surgery, tumor, or transplant?
 Yes No Are you currently on renal (kidney) hemodialysis or peritoneal dialysis?
 Yes No Have you received an intravenous injection of MRI contrast in the past month?
 Yes No Do you have myeloma?
 Yes No Is there a family history of renal disease?
 Yes No Are you currently taking Metformin, long-term non-steroidal anti-inflammatory drugs, or chemotherapy?

I attest that the above information is correct to the best of my knowledge. I do not have a pacemaker, or have had brain surgery requiring aneurysm clips, nor do I have a neuro-stimulator, and I understand that having these items in the MRI room could result in serious injury or death.

Patient/Legal Guardian Signature _____ Witness Signature _____

Gadolinium Given-ml/lot# _____ Technologist Signature _____

Please mark on the figure(s) below
the location of any implant or metal
inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern **BEFORE** you enter the MR system room.

REASON FOR TODAY'S EXAM?:

ONSET/DURATION OF SYMPTOMS:

RESULT OF AN INJURY OR ACCIDENT? Y or N (circle)

WORK RELATED ? Y or N (circle) MVA? Y or N (circle)

DATE OF INJURY OR ACCIDENT?

For Office Use Only:

Creatinine: _____ GFR: _____ Date: _____ Location: _____

Patient Position: _____

Sequences Obtained:
