MRI PATIENT HISTORY AND CONSENT

Patient Name: _____ Height: _____

Date of Birth: _____ Age: _____ Weight: _____

Date of Exam: _____ Sex: Male ☐ Female ☐

Have you taken any anxiety or sedation medication today? Yes ☐ No ☐ If yes, what? _____

THE ITEMS BELOW CAN INTERFERE WITH MRI IMAGING - some can be hazardous to your safety

Have you ever had:

An injury to your eye involving metal? Yes ☐ No ☐

A metallic fragment of foreign body in your head, face, neck or body? Yes ☐ No ☐

If yes to either, were you tested to ensure all metal was removed? Yes ☐ No ☐

Surgical Implants	YES	NO	**Surgical Implants**	YES	NO
Cardiac Pacemaker			Shunt (spinal or intraventricular)		
Electric Implant or Device			Prosthesis (eye, penile, etc)		
Spinal Cord Stimulator			Radiation Seeds or Implants		
Neurostimulator			Artificial Limb		
Aneurysm Clip			Joint Replacement		
Cochlear/Ear Implant			Port/Catheter		
Internal Electrodes or Wires			Breast Tissue Expander		
Cardiac Stent/Coil/Filter			Breast Implants		
Artificial Heart Valve			Implanted Device		
Glucose Monitor/ Insulin Pump			Medication Patch on skin		
Any Magnetic Implant			Bone/Joint Pin, Screw, Nail, Plate		
IUD			Dentures or Partial Plates		
Tattoo or Permanent Makeup			Hearing Aid (remove before scan)		

Skin Warming

MRI Radiofrequency has the potential to cause tissue heating. The Technologist will take several precautions to avoid this. **Alert the technologist immediately if you notice any heating sensations during your MRI scan.**

Piercings, Cosmetic Implants, Tattoos and Permanent Makeup

A small number of patients have experienced transient skin irritation, swelling, bruising or heating sensations at the sight of piercings, cosmetic implants, tattoos and permanent makeup in association with MR procedures. **Individuals with these items should inform the technologist so precautions can be taken.**

Injury/Surgical/Radiation History

Did you injure the area of interest? Yes ☐ No ☐ If yes, describe: _____

Have you had another exam of the area we are scanning? Yes ☐ No ☐ If yes, describe: _____

Have you had surgery or radiation therapy on the area? Yes ☐ No ☐ If yes, describe: _____

Please list any other surgeries (include dates): _____

Signature

I attest that the information on this form is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the MR procedure I am about to undergo.

Patient/Guardian Signature: _____ Date: _____

FOR STAFF USE

Screening performed by: ☐ MR Technologist ☐ Nurse ☐ Radiologist ☐ Other: _____

Staff Signature: _____ Date: _____