ADVANCED IMAGING CONCEPTS, PL.

Date: _____ **MRI PATIENT FORM**

Name _____ Age _____ Weight _____

Date of Birth _____/_____/_____ Male / Female

1.Reason for MRI and/or Symptoms:_____

2.History of Cancer: No /yes

If yes, please describe: _____

3. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind?
No / Yes
If yes, please indicate the date and type of surgery:

Type of surgery _____

_____

4. Have you experienced any problem related to a previous MRI examination or MR procedure?
No / Yes

If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?
No / Yes

If yes, please describe: _____

6. Are you allergic to any medication? No / Yes

If yes, please list: _____

7. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? No / Yes

If yes, please describe: _____

8. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures? No / Yes

If yes, please describe: _____

9. **For female patients:** Are you Pregnant or Breast Feeding No / Yes

FOR OFFICE USE ONLY:

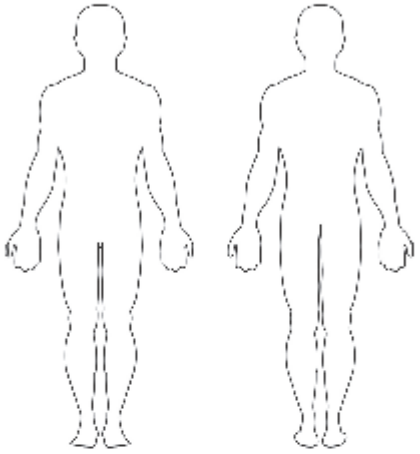
Contrast Used: _____ Injection Site: _____ Adverse Reaction: No/ Yes

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.**

Please indicate if you have any of the following:

- ❑ Yes ❑ No Aneurysm clip(s)
- ❑ Yes ❑ No Cardiac pacemaker
- ❑ Yes ❑ No Implanted cardioverter defibrillator (ICD)
- ❑ Yes ❑ No Electronic implant or device
- ❑ Yes ❑ No Magnetically-activated implant or device
- ❑ Yes ❑ No Neurostimulation system
- ❑ Yes ❑ No Spinal cord stimulator
- ❑ Yes ❑ No Internal electrodes or wires
- ❑ Yes ❑ No Bone growth/bone fusion stimulator
- ❑ Yes ❑ No Cochlear, otologic, or other ear implant
- ❑ Yes ❑ No Insulin or other infusion pump
- ❑ Yes ❑ No Implanted drug infusion device
- ❑ Yes ❑ No Any type of prosthesis (eye, penile, etc.)
- ❑ Yes ❑ No Heart valve prosthesis
- ❑ Yes ❑ No Eyelid spring or wire
- ❑ Yes ❑ No Artificial or prosthetic limb
- ❑ Yes ❑ No Metallic stent, filter, or coil
- ❑ Yes ❑ No Shunt (spinal or intraventricular)
- ❑ Yes ❑ No Vascular access port and/or catheter
- ❑ Yes ❑ No Radiation seeds or implants
- ❑ Yes ❑ No Swan-Ganz or thermodilution catheter
- ❑ Yes ❑ No Medication patch (Nicotine, Nitroglycerine)
- ❑ Yes ❑ No Any metallic fragment or foreign body
- ❑ Yes ❑ No Wire mesh implant
- ❑ Yes ❑ No Tissue expander (e.g., breast)
- ❑ Yes ❑ No Surgical staples, clips, or metallic sutures
- ❑ Yes ❑ No Joint replacement (hip, knee, etc.)
- ❑ Yes ❑ No Bone/joint pin, screw, nail, wire, plate, etc.
- ❑ Yes ❑ No IUD, diaphragm, or pessary
- ❑ Yes ❑ No Dentures or partial plates
- ❑ Yes ❑ No Tattoo or permanent makeup
- ❑ Yes ❑ No Body piercing jewelry
- ❑ Yes ❑ No Hearing aid
  (Remove before entering MR system room)
- ❑ Yes ❑ No Other implant _____
- ❑ Yes ❑ No Breathing problem or motion disorder
- ❑ Yes ❑ No Claustrophobia

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



IMPORTANT INSTRUCTIONS

Before entering the MR system room, you will be asked to change into a gown. Please understand that this is a safety requirement and not optional. You must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, and watch.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

Please consult the MRI Technologist if you have questions or concerns before you enter the MR Suite.

I have read and understood and hereby consent to this MRI examination. I understand the use of contrast material may be recommended by my doctor for this exam.

Patient Signature_____Date:_____

I have reviewed and discussed these safety items with the above signed patient or guardian and approve this patient for magnetic resonance imaging.

Technologist Signature: _____ Date: _____