MONUMENT/ 9A IMAGING & DIAGNOSTIC CENTER
SAFETY SCREENING AND CONSENT FORM FOR MRI EXAMS

DATE: _____

PATIENT INFORMATION:

NAME: _____
AGE: _____ DOB: _____ M ____ F ____
HEIGHT: _____ WEIGHT _____ LBS
REFERRING DR: _____
WHY IS THIS STUDY BEING REQUESTED: _____
_____
OTHER PROBLEMS OR CONCERNS? _____
_____

ANY PRIOR MRI EXAMS SIMILAR TO THE EXAM YOU ARE HAVING TODAY? YES _____ NO _____
*If yes, please provide information on date and location of prior exam

MEDICAL HISTORY:

ALLERGIES TO FOOD/DRUGS/LATEX:
_____
_____
LIST PRIOR MAJOR SURGERIES (TYPE & YEAR) _____
_____
ANY PERSONAL HISTORY OF CANCER?
YES ____ NO ____
*If yes, please indicate type of cancer(s), when diagnosed, and any treatment. _____
_____
_____
_____

FOR FEMALE PATIENTS:

ARE YOU PREGNANT? YES_____ NO _____
NURSING? YES _____ NO _____
ANY POSSIBILITY THAT YOU COULD BE PREGNANT?
YES _____ NO _____
*If you are pregnant (or think you may be), alert the technologist immediately. This exam should only be performed if considered essential as determined by your obstetrician and the radiologist.

(PLEASE SEE OTHER SIDE)

PLEASE COMPLETE THE FOLLOWING SECTION REGARDING INTRAVENOUS (I.V.) MRI CONTRAST

HAVE YOU EVER RECEIVED MRI CONTRAST?
YES _____ NO _____
IF YES, HAVE YOU EVER HAD AN ADVERSE REACTION?
YES _____ NO _____
If so, describe: _____
_____

DO YOU HAVE .....

DIABETES?	Y	N
KIDNEY PROBLEMS OR SINGLE KIDNEY?	Y	N
DO YOU TAKE MEDICATIONS WHICH IMPAIR KIDNEY FUNCTION? (CHEMOTHERAPY, LONG-TERM N-SAIDS)	Y	N
CARDIOVASCULAR DISEASE?	Y	N
ASTHMA?	Y	N

I.V. Contrast is often required for diagnosis of certain conditions. I.V. Contrast for MRI is safe and uneventfully administered to millions of patients each year. Patients with moderate/severe pre-existing renal dysfunction; however, are at increased risk for development of a serious and potentially fatal condition known as Nephrogenic-Systemic Fibrosis. Please alert the technologist if you have any kidney problems.

Occasionally, patients may experience mild adverse reactions (vomiting, hives) following I.V. contrast administration, but severe reactions are exceedingly rare. The facility and the attending physician are prepared to treat any patient who may develop a rare adverse reaction.

If you have specific questions or concerns, please inform the technologist or ask to speak with the radiologist. You have the right to refuse I.V. contrast or any medical exam.

I attest that I have accurately completed page 1. I understand that the high magnetic field around an MRI machine could result in serious injury or even death in patients who may have items identified on page 1.

FOR TECHNOLOGIST USE

Technologist should review form carefully and consult radiologist regarding positive answers or other concerns. Attach M.D order to this sheet.

Injection site: _____ Vol. of contrast: _____
Problems/Complications/Comments: _____
_____
Tech Signature: _____

THE FOLLOWING ITEMS COULD CAUSE YOU SERIOUS HARM. PLEASE PROVIDE A "YES" OR "NO" ANSWER FOR EVERY ITEM.

DO YOU HAVE .....

PACEMAKER OR DEFIBRILLATOR?	Y	N
BRAIN ANEURYSM CLIP?	Y	N
COCHLEAR OR EAR IMPLANT?	Y	N
BRAIN NEUROSTIMULATOR, VENTRICULAR SHUNT OR OTHER IMPLANTED BRAIN DEVICE? *If yes, please provide type and date implanted:____	Y	N
OTHER NEUROSTIMULATOR?	Y	N
BIOSTIMULATOR OR IMPLANTED DRUG PUMP (*E.G. Insulin, baclofen, Chemotherapy, pain medicine)	Y	N
ANY TYPE OF COIL, FILTER, OR STENT?	Y	N
ANY TYPE OF ELECTRONIC MECHANICAL OR MAGNETIC IMPLANT?	Y	N
OTHER METALLIC IMPLANT OF ANY TYPE (PINS, RODS, SCREWS, NAILS, PLATES, WIRES, ECT.)	Y	N
ARTIFICIAL LIMB OR OTHER BODY PART?	Y	N
BODY IMPLANT OF ANY TYPE (BREAST, PENILE, ETC)	Y	N
ANY TYPE OF METAL OBJECTS (SHRAPNEL, BULLET, BB)?	Y	N
ANY HISTORY OF WELDING OR METAL IN THE EYES?	Y	N
ARTIFICIAL HEART VALVE?	Y	N
ANY OTHER IMPLANTED ITEM NOT MENTIONED ABOVE?	Y	N

*IF YES TO ANY ANSWER ABOVE, PLEASE PROVIDE DETAILS BELOW: (HAVE IMPLANT CARD AVAILABLE, IF APPLICABLE) _____

_____

_____

_____

FACILITY DISCLAIMER

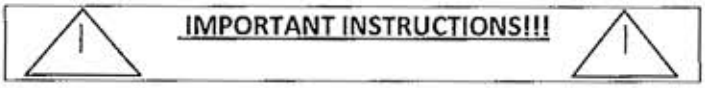
Our Facility will not be held responsible for any items that we have mentioned and you failed to remove prior to entering the MRI room.

THE FOLLOWING ITEMS COULD CAUSE INJURY OF INTEREFERE WITH YOUR MRI EXAM. PLEASE REMOVE ANY OF THE LISTED ITEMS APPLICABLE AND STORE THEM IN YOUR LOCKER OR GIVE THEM TO THE TECHNOLOGIST. PLEASE PROVIDE A "YES" OR "NO" ANSWER FOR EVERY ITEM.

DO YOU HAVE .....

HEARING AID?	Y	N
NUMEROUS SURGICAL CLIPS/STAPLES?	Y	N
DENTURES, DENTAL APPLIANCES?	Y	N
WIG, HAIR IMPLANTS?	Y	N
LARGE TATTOOS?	Y	N
PERMANENT/TATTOOED MAKEUP?	Y	N
BODY PIERCINGS?	Y	N
RADIATION SEEDS?	Y	N
DIAPHRAM/IUD, PESSARY?	Y	N
METALLIC SURGICAL MESH?	Y	N
MEDICATION PATCH?	Y	N
HAIR ACCESSORIES? (BOBBY PINS, BARRETTES, CLIPS)	Y	N

PLEASE REMOVE ALL METALLIC ITEMS, WALLETS, AND ALL JEWELRY AND HEARING AIDS!!!!



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 clips, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, and clothing with metallic threads.

Please consult the MRI Technologist and/or Radiologist if you have any questions or concerns BEFORE you enter the MR system room.

PLEASE SIGN BELOW

SIGN / DATE: _____

RELATIONSHIP (IF OTHER THAN PATIENT): _____

_____

WITNESS: _____