

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_ Weight \_\_\_\_\_

Have you ever had an MRI before?  Yes  No If yes please list \_\_\_\_\_

The FDA has not established any criteria under which a pregnant woman may be scanned. Therefore, it is the policy of this facility that MR imaging NOT be routinely performed on a woman known or suspected to be pregnant. **Are you pregnant or breastfeeding?**  Yes  No

The following items can cause harm to you as a patient in the MRI scanner. Please check the following as it applies. Please be as accurate as possible.

Do you have any of the following?	Yes	No	Not Sure
IUD, diaphragm or pessary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired renal function	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker or Defibrillator	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
History of Hepatic Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain or Infusion pump	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body piercing (including ears)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing aid(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Limbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary Stent or bypass clips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vena Cava Filter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Permanent eyeliner /tattoos	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cochlear (ear) Implant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain Aneurysm Clips	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurostimulator (Tens Unit)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Claustrophobia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shrapnel or Bullets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Could you have metal in either eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had metal removed from either eye	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever had brain surgery? \_\_\_\_\_

List any other metal in your body \_\_\_\_\_

Brief explanation for your visit \_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_

**Please remove all metallic objects before entering the MRI** including keys, hairpins, barrettes, jewelry, watch, safety pins, paper clips, money clips, credit cards, coins, wallet, belt, metal buttons, pocket knife and clothing with metal in the material. Please note you will be required to wear earplugs or other hearing protection during the MR procedure to prevent possible hazard related to acoustic noise. During the exam you will receive an injection of gadolinium (enhancing agent). 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.**

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: \_\_\_\_\_