Women's Center For Radiology

Weight: _____ **Height:** _____

State reason for MRI today: _____

Any prior imaging of the area to be scanned today? **Yes** **No**
(if **YES,** when and where were they performed?) _____

Any prior surgeries on the area being scanned today? **Yes** **No**
(if **YES**, please list): _____

Do you have any history of cancer? **Yes** **No**
(if **YES,** please explain): _____

Please indicate if you have any of the following:

Yes	**No**	Cardiac Pacemaker or Pacemaker Wires
Yes	**No**	Implanted Cardiac Defibrillator
Yes	**No**	Brain Aneurysm Clips/Brain Surgery
Yes	**No**	Neurostimulator
Yes	**No**	Heart surgery / Heart valve
Yes	**No**	Shunts / Stents / Filters / Coils
Yes	**No**	Eye surgery / Implants / Retinal tack
Yes	**No**	Ear surgery / Cochlear Implants / Staples
Yes	**No**	Vascular Access / Port Catheter
Yes	**No**	Orthopedic Pins / Rods / Screws / Prosthesis
Yes	**No**	Other Implant:
Yes	**No**	Dentures / Partials / Dental Implants
Yes	**No**	Hearing Aids
Yes	**No**	Implanted Drug Pump
Yes	**No**	Breast Tissue Explanders
Yes	**No**	Medication Patch
Yes	**No**	History of Metal Grinding or Welding
Yes	**No**	Gunshot Wouds / Shrapnel / BB
Yes	**No**	Tattoos / Permanent Make-up
Yes	**No**	Body Piercing (Including Ears)

Female Patients

Yes	**No**	Menopausal
Yes	**No**	Chance of Pregnancy
Yes	**No**	Breastfeeding
Yes	**No**	IUD, Diaphragm or Pessary
Yes	**No**	Oral Contraceptives
Yes	**No**	Hormonal Treatment
Yes	**No**	Fertility Medication or Treatments

If yes, describe: _____

Date of last menstrual period: _____

Please explain any items marked YES: _____

Please list any allergies: _____

Have you ever received an injection of MRI contrast in the past? **Yes** **No**

Have you had a prior allergic reaction to gadolinium (MRI contrast)? **Yes** **No**

(if YES, please explain): _____

Yes	**No**	History of Diabetes	**Yes**	**No**	History of liver disease or liver transplant
Yes	**No**	History of Hypertension	**Yes**	**No**	History of kidney disease, kidney failure, are you on dialysis

Your signature below indicates that all the information above is accurate, you have ready and understand the above information, all of your questions have been answered and you consent to the procedure(s).

MRI CONTRAST CONSENT

Your physician has determined that an MRI study with gadolinium is needed to help diagnose your medical condition. Gadolinium contrast is given by injection into a vein and aids in distinguishing normal from abnormal tissues. The gadolinium contrast agent you will recieve has been approved as safe and effective by the U.S. Food and Drug Administration (FDA). As with any medication, a small chance exists that you may have a reaction to it.

Any injection carries with it the rish of damage to a vein, artery, nerve or skin, risk of infection and risk of allergic reaction. Many patients receiving gadolinium may experience a momentary cold feeling in the area of injection. On very few occassions, a patient may experience an allergic reaction to gadolinium. The most common of the reactions are pain at the injection site, nausea, headache, dizziness, itching, rash, hives or temporary breathing difficulty.
Gadavist Medication Guide provided.
The use of gadolinium contrast is optional. However, your physican believes the potential diagnostic benefits for you exceed these risks. By signing below you understand the statements above and agree to receive gadolinium contrast for you exam.

Patient / Guardian Signature: _____ **Date:** _____

IMPORTANT INSTRUCTIONS:
Before entering the MRI room, you must remove all metallic objects including cell phones, jewelry, eye glasses, hair pins, barrettes, watch, credit cards, bank cards, magnetic strip cards, pens, pocket knife, etc.

Technologist Use Only:

Tech: _____
Contrast: _____
ML/Lot#: _____

Notes: _____