

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

With patient safety as our primary concern, please examine the following and answer each question as accurately as possible for your safety.

**YES NO**

- Cardiac Pacemaker/Leads/Defibrillator **\*\*\*\*If Yes, Please stop and let the Front Desk know\*\*\*\***
- Tissue Expanders (Breast) **\*\*\*\*If Yes, Please stop and let the Front Desk know\*\*\*\***
- Stimulators (Brain, Spinal Cord, Bone, Bladder, etc.) Device \_\_\_\_\_ Model No \_\_\_\_\_
- Electronic Implants/Devices (Loop Recorder, etc.) Device \_\_\_\_\_ Model No \_\_\_\_\_
- Brain Aneurysm Clips/Coils \_\_\_\_\_
- Intraventricular/Spinal Shunt (Programmable) \_\_\_\_\_
- Intravascular Stents, Valves, Filter(IVC), Coils, etc. \_\_\_\_\_
- Medicine Infusion Pumps (Insulin, Pain, etc.) \_\_\_\_\_
- Joint Replacements (Hip, Knee, Shoulder, etc.) \_\_\_\_\_
- Pins/Rods/Screws/Plates/Wires/etc. \_\_\_\_\_
- Surgical Staples/Sutures/Mesh(Hernia) \_\_\_\_\_
- Shrapnel/Metal Fragments/Injury to Eyes Involving Metal \_\_\_\_\_
- If Yes**, Was it removed by a Doctor? \_\_\_\_\_
- Any type of Inner Ear Prosthesis or Cochlear Implants \_\_\_\_\_
- Artificial Prosthetic/Implant (Eye, Penile, etc.) \_\_\_\_\_
- Personal History of Cancer  
→**If Yes**, Type \_\_\_\_\_ Year \_\_\_\_\_ Treatment \_\_\_\_\_
- Any type of Surgery or Procedure in last 6 weeks \_\_\_\_\_
- Endoscopy/Colonoscopy Clips placed in last 6 weeks, Swallowed Endoscopy Pill Camera in last week \_\_\_\_\_
- Port or Catheter \_\_\_\_\_
- Seizures or Recent Fever \_\_\_\_\_
- Tattoos or Permanent Make-Up \_\_\_\_\_
- Did patient take Oral Sedation Medication? \_\_\_\_\_
- If Yes**, Does Patient have a Driver? \_\_\_\_\_
- Previous Surgery to Area of Interest of Today's Exam?  
→**If Yes**, When? \_\_\_\_\_

**\*\*\*\*All of the following must be removed and locked up in locker provided prior to going into scan room\*\*\*\***

- Transdermal/Medication Patch/Continuous Glucose Monitor
- Any Loose metal (Watch, Jewelry, Hair Pins, Piercings, Etc.)
- Removable Dental Work (Dentures, Partials)
- Hearing Aids

\_\_\_\_\_ (**Please Initial**) I understand for my safety and for the safety of the Technologist, I am required to remove personal clothing/belongings and change into scrub pants and a gown provided by Iowa Radiology. Personal belongings and clothing will be locked up in a locker prior to exam and the key will remain in the scan room with the patient throughout the scan.

**I have reviewed the above information and answered the questions to the best of my knowledge.**

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Signature of Patient, Parent, or Legal Representative \_\_\_\_\_ Date \_\_\_\_\_

**Form Information Reviewed By:**

MRI Technologist \_\_\_\_\_ Date \_\_\_\_\_



# MRI SCREENING AND HISTORY FORM

## PATIENT INFORMATION:

Area Being Scanned Today: \_\_\_\_\_

Surgical History: \_\_\_\_\_

Current Symptoms: \_\_\_\_\_

How long have the symptoms persisted? \_\_\_\_\_

Are the symptoms the result of an injury or trauma? \_\_\_\_\_

Prior MRI, CT, US, X-Ray on the Area of Interest of Today's Exam? \_\_\_\_\_

<i>(For Technologist Use When Giving Contrast)</i>		
<b>Possibility of Pregnancy</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Chronic Kidney Disease</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Diabetic</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Patient on Dialysis</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>MRI Contrast Agent Used</b>	<input type="checkbox"/> Clariscan	<input type="checkbox"/> Eovist
<b>Dose:</b>	_____ mL Given	_____ mL Discarded
<b>Labs(if Applicable)</b>	Creatinine _____ e(GFR) _____	Date _____

## MRI Contrast Information and Consent

Due to your medical history or as requested by your physician, an injection of MRI Gadolinium Contrast may be necessary to aid the radiologist in evaluating your MRI scan. This injection may allow the radiologist to identify additional details about your condition that might not be apparent without the use of the contrast agent. The contrast agent will be injected into a vein at which time there may be a slight burning at the injection site. The contrast agent is filtered out of the blood stream by your kidneys – in some cases the liver as well – and excreted from your body. The contrast agent will be eliminated from your body approximately 24-48 hours after injection. Side effects of gadolinium based contrast agents are very rare; the most common side effects are nausea and/or vomiting, headache, and local discomfort at the injection site. Severe reactions and death are extremely rare.

If you wish to discuss your exam further with a physician, please inform the technologist and they will reschedule your exam to a later date.

I understand I have the right to refuse the use of Gadolinium Based Contrast Agents and still undergo the MRI scan, although it may result in a limited scan.

**Your signature below indicates that you have read and understand the Medication Guide for Clariscan(gadoterate meglumine) or the Medication Guide for Eovist(gadoxetate disodium) provided, as well as the risks described above and agree to have an MRI and/or MRA with IV Gadolinium Contrast**

\_\_\_\_\_  
Signature of Patient, Parent, or Legal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness/MRI Technologist

\_\_\_\_\_  
Date