Highland Clinic MRI

1455 E Bert Kouns Industrial Loop Shreveport, LA 71105 Suite 103 Phone: (318) 798-4472

NAME:_____

ADDRESS:_____ CITY, ST. ZIP:_____

DOB:_____ AGE:_____ HEIGHT:_____ WEIGHT:_____ MRN:_____

MRI PATIENT SCREENING QUESTIONNAIRE

Have you had prior surgery of any kind? **YES** ☐ **NO** ☐

If yes, please indicate date and type of surgery: _____

Have you had an injury to the eye involving a metallic object (i.e. metallic slivers, foreign body)? **YES** ☐ **NO** ☐

If yes, please describe: _____

Have you ever been injured by a metallic object or foreign body (i.e. BB, bullet, shrapnel, etc.)? **YES** ☐ **NO** ☐

If yes, please describe: _____

Are you Claustrophobic: **YES** ☐ **NO** ☐ Do you have a sedative to take? **YES** ☐ **NO** ☐

Female Patients:

Could you possibly be pregnant? **YES** ☐ **NO** ☐

Date of last menstrual period: _____ Date of hysterectomy: _____

Are you post menopausal? **YES** ☐ **NO** ☐

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure.
Please *CHECK* yes or no to each of the following items.

	Yes	No		Yes	No
Brain aneurysm clip(s) or aneurysm coiling	☐	☐	Wire mesh implant	☐	☐
Shunts	☐	☐	Surgical staples, clips, or metallic sutures	☐	☐
Cardiac pacemaker (or pacemaker lead wires)	☐	☐	Artificial or prosthetic limb	☐	☐
Implanted cardioverter defibrillator (ICD)	☐	☐	Joint replacement	☐	☐
Artificial heart valve	☐	☐	Bone/joint pin, screw, nail, wire, plate, etc.	☐	☐
Stent(s) (e.g. cardiac, carotid, renal, iliac, etc.)	☐	☐	Harrington rods	☐	☐
Inferior Vena Cava (IVC) filter	☐	☐	Hearing aids (Remove before scan)	☐	☐
Swan-Ganz or thermodilution catheter	☐	☐	Cochlear, otologic, or other ear implant	☐	☐
Vascular access port and/or catheter	☐	☐	Eye prosthesis/device/implant	☐	☐
Insulin or other infusion pump	☐	☐	Tissue expander (e.g. breast)	☐	☐
Transdermal medication patch	☐	☐	IUD	☐	☐
Electronic implant or device	☐	☐	Penile implant	☐	☐
Magnetically activated implant or device	☐	☐	Body piercings (Remove before scan)	☐	☐
Neurostimulator	☐	☐	Tattoo or permanent cosmetics	☐	☐
Spinal cord stimulator	☐	☐	Dentures or partial plates	☐	☐
Bone growth/bone fusion stimulator	☐	☐	Other implant:_____		

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MRI PATIENT SCREENING QUESTIONNAIRE

If you answered **YES** to any of the questions on the front page, please discuss any concerns and/or issues you may have, with your MR Technologist.

Instructions for the Patient, Parent, Guardian:

1. Remove **ALL** body piercing jewelry and **ALL** hair accessories.
2. Remove dentures, false teeth, partial dental plates, retainers.
3. Remove hearing aids and glasses.
4. Remove **ALL** clothing and change into a hospital gown.
5. Lock your clothes and valuables in the locker provided and remove the key.
6. Please use the restroom before your MRI exam.
7. Please make sure that you receive a pair of earplugs before your MRI exam begins.

I attest the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and I have had the opportunity to ask questions regarding the information on this form.

_____ _____

Patient/Parent/Guardian Signature Patient/Parent/Guardian Printed Name

_____ _____

Technologist's Signature Technologist's Printed Name

FOR MRI STAFF USE ONLY

Bun:_____ Creatinine:_____ GFR:_____ Date of Labs:_____

IV Guage:_____ IV Type: ☐ Butterfly ☐ Angio-cath ☐ Left ☐ Right Location: _____

Port: ☐ Standard ☐ Power

Contrast Type:_____ Injection Rate:_____ Injection Amount:_____

Lot Number:_____ Exp date:_____

Highland Clinic
Consent for MRI and MRI Contrast

1455 E Bert Kouns Industrial Loop Shreveport, LA 71105 Suite 103 Phone: (318) 798-4472

Patient Name:_____ MRN:_____ Date:_____

MRI EXAMINATION (for office use) :_____

Your physician has scheduled you for an MRI examination. If your MRI does not require an injection of contrast media, there are very few risks associated with your examination. The MRI scanner produces a constant strong magnetic field, so if you have any tattoos, metal implants, and/or clips within or on your body please inform the technologist. Metal earrings, metal body piercings, and necklaces must be removed prior to the study. MRI scanning produces a loud tone that can cause damage to the inner ear if appropriate sound protection is not used. Earplugs will be provided to protect your ears.

Please circle "yes or no" to the following questions:

Yes No Have you ever had an MRI with contrast material injected into your veins?

Yes No If yes, did you experience any problems? Please describe:_____

Please list all allergies:_____

_____

Some MRIs are performed using intravenous contrast. The IV contrast media used is "gadolinium." It is a water based contrast and it's not iodine. It is considered quite safe; however, any injection carries some risk, including injury to a nerve, artery or vein, infection or reaction to the contrast media being injected. Occasionally, reactions to the contrast media occur.

Mild non-allergic
- Coldness, warmth, or pain at the injection site, nausea/vomiting, headache, dizziness

Mild allergic
- A generalized itchy rash or reddening of the skin, local pain and tenderness at the injection site due to irritation of the vein

Moderate allergic
- A mild asthma type attack consisting of chest tightness and some difficulty breathing

Severe allergic reaction
- Severe difficulty breathing, severe swelling of the face mouth or airways.

The Radiologists are trained to treat these types of reactions. Very rarely, death has occurred related to IV contrast administration. The risk of such a severe consequence is similar to that of any medication. Please alert us if you feel any pain, unusual sensation, or any of the side effects described above.

Nephrogenic Systemic Fibrosis (NSF) is a condition that occurs in patients with moderate to end-stage kidney disease. Reports have identified a link between NSF and exposure to Gadolinium containing contrast agents.

High risk patients include those with **History** of:
- Age >60
- Kidney disease
- Dialysis
- Kidney Transplant
- Single Kidney
- Kidney Surgery
- Known cancer involving the kidney(s)
- High blood pressure
- Diabetes mellitus
- Lupus
- Multiple Myeloma

If you have a history of one of the above conditions, your most recent laboratory results will be reviewed prior to your exam. If you do not have recent laboratory results, labs must be obtained prior to the examination to ensure patient health and safety.

Your physician has considered the risks listed above before recommending this procedure and he/she believes that the diagnostic benefits far outweigh the risk involved. The purpose of this form is to inform of the procedure and most of its possible side effects and complications.

I hereby state that I have read and understand the information provided above. All questions about the procedure(s) for which I am scheduled have been answered in a satisfactory manner. Your signature below is indication that you have read and understand the information provided herein and your signature represents authorization for the MRI examination with contrast. Your signature is considered necessary because of the possible complications explained above.

_____ _____

(Patient/Guardian Signature) *(Print Patient/Guardian Name)*