

## PATIENT CONSENT AND SCREENING FORM

NAME: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_ AGE: \_\_\_\_\_ MR# \_\_\_\_\_

There are no known risks associated with being within this particular magnetic field. You will be instructed to place everything you have brought with you into a locker, including watches, credit cards, bank cards, jewelry (including rings), dentures, wigs and hairpins. You may **NOT** be eligible for the MRI study if you have any of the following. Some implants or devices may be hazardous to you in the MR environment. No objects of any types may be brought into the scan room without supervision or a technologist approval. Patients that request someone to accompany them in the scan room must fill out this same consent form prior to entry.

### POTENTIAL DISCOMFORT

Please let us know if you have any of the following so we can prevent any discomfort:

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Are you claustrophobic?  | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Are you scheduled for sedation by the nurse?   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Is your driver aware they need to stay for the duration of your exam if you are being sedated? | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Has your Doctor given you a prescription for relaxation?                                       | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Do you have difficulty lying flat?   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

### POTENTIAL RISK

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Are you allergic to any medication?<br>Please list: _____  | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Have you ever had a reaction to any contrast injection?<br>If so, what was your reaction: _____                          | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Do you have a history of any kind of Kidney Disease?<br>If so, please explain: _____                                     | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Do you have hypertension? (High Blood Pressure)  | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Do you take medication?<br>Please list: _____<br>_____   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Are you diabetic?<br>Do you take pills or insulin? (please circle one)<br>What do you take and how often? _____<br>_____ | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Do you have any problems where you require oxygen?   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Do you have sleep apnea?   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Do you have any removable dentures or partials?<br><br>If yes, you may be asked to remove them.                          | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

Patients with braces or metallic dental fillings may experience some slight tingling in your mouth. If you experience any problems during your exam, please let us know.

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| Do you have a hearing aid?<br>You must remove them before going into the scan room. | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
|---|------------------------------|-----------------------------|

### COSMETIC

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| Do you have any tattoos, permanent eyeliner, or any type of permanent makeup?          | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Do you have any body piercing?<br>If yes, what is pierced? _____ and how recent? _____ | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

**ALL BODY PIERCINGS MUST BE REMOVED BEFORE GOING INTO THE SCAN ROOM.**

**For female patients:**

Date of your last menstrual period: \_\_\_\_\_

Is there any chance that you may be pregnant? YES  NO

If yes, has your doctor explained the risk? YES  NO

**There are additional forms to sign if your answer was YES to the above.**

Are you currently breast feeding? YES  NO

Have you had a hysterectomy or tubal ligation? YES  NO   
(Please circle one if applicable)

Do you have an IUD and if yes what kind? \_\_\_\_\_ YES  NO

**For male patients:**

Any type of prosthesis? (penile implant) YES  NO

If yes, what kind? \_\_\_\_\_

\*Not all penile prosthesis are MRI compatible and will need to be cleared for safety\*

**Please read carefully and indicate if you have any of the following:**

- |  |  |  |  |
|--|--|--|--|
| <b>ANEURYSM VASCULAR CLIPS</b>                       | YES <input type="checkbox"/> NO <input type="checkbox"/> | <b>HISTORY OF RADIATION OR CHEMO</b>                     | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <b>CARDIAC PACEMAKER</b>                             | YES <input type="checkbox"/> NO <input type="checkbox"/> | <b>RADIATION SEEDS OR IMPLANTS</b>                       | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <b>SHUNT</b>   | YES <input type="checkbox"/> NO <input type="checkbox"/> | <b>TISSUE EXPANDER</b>                                   | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <b>ICD</b><br>(IMPLANTED CARDIOVERTER DEFIBRILLATOR) | YES <input type="checkbox"/> NO <input type="checkbox"/> | <b>WERE YOU A GRINDER, MACHINIST,<br/>OR CARPENTER?</b>  | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <b>ELECTRONIC IMPLANT OR DEVICE</b>                  | YES <input type="checkbox"/> NO <input type="checkbox"/> | <b>METALLIC SHAVINGS, SLIVERS IN EYES</b>                | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <b>MAGNETICALLY ACTIVATED IMPLANT<br/>OR DEVICE</b>  | YES <input type="checkbox"/> NO <input type="checkbox"/> | <b>EYELID SPRING OR WIRE</b>                             | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <b>CARDIAC METAL HEART VALVE<br/>PROSTHESES</b>      | YES <input type="checkbox"/> NO <input type="checkbox"/> | <b>EYE ORBITAL PROSTHESES</b>                            | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <b>INTERNAL ELECTRODES OR WIRES</b>                  | YES <input type="checkbox"/> NO <input type="checkbox"/> | <b>METAL MIDDLE &amp; INNER EAR<br/>PROSTHESES</b>       | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <b>NEUROSTIMULATION SYSTEM</b>                       | YES <input type="checkbox"/> NO <input type="checkbox"/> | <b>BULLETS, BB'S OR SHRAPNEL</b>                         | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <b>SPINAL CORD STIMULATOR</b>                        | YES <input type="checkbox"/> NO <input type="checkbox"/> | <b>ANY METALLIC FRAGMENT OR<br/>FOREIGN BODY</b>         | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <b>INSULIN OR OTHER INFUSION DEVICE</b>              | YES <input type="checkbox"/> NO <input type="checkbox"/> | <b>FRESH POSTOPERATIVE SURGICAL<br/>STAPLES OR CLIPS</b> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <b>WIRE MESH IMPLANT</b>                             | YES <input type="checkbox"/> NO <input type="checkbox"/> | <b>BONE/JOINT PIN, SCREW, NAIL, WIRE<br/>PLATE, ETC</b>  | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <b>VASCULAR ACCESS PORT AND/OR<br/>CATHETER</b>      | YES <input type="checkbox"/> NO <input type="checkbox"/> | <b>JOINT REPLACEMENT (HIP, KNEE, WRIST)</b>              | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <b>SWAN-GANZ OR THERMODILUTION<br/>CATHETER</b>      | YES <input type="checkbox"/> NO <input type="checkbox"/> | <b>MEDICATION PATCH</b>                                  | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| <b>METALLIC FILTER OR COIL</b>                       | YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |

**HOW DID YOU HEAR ABOUT OUR FACILITY?**

Please check one:  Physician  Radio  Friend/Family  Yellow Pages  Media  Other

**CONSENT**

I have read and understand the above, have had my questions and concerns answered and consent to the MRI examination.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_