MRI SCREENING FORM

SJRA
SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete
DOS: ____ / ____ / ____

PATIENT #: _____

PATIENT NAME: _____ _

DOB: _____ / _____ / _____ / AGE: _____ / SEX: _____

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. DO NOT ENTER the MR System room or MR environment if you have any questions or concerns regarding an implant, device or object. Consult the MRI technologist or Radiologist BEFORE entering the MR room. The MR system magnet is ALWAYS ON.

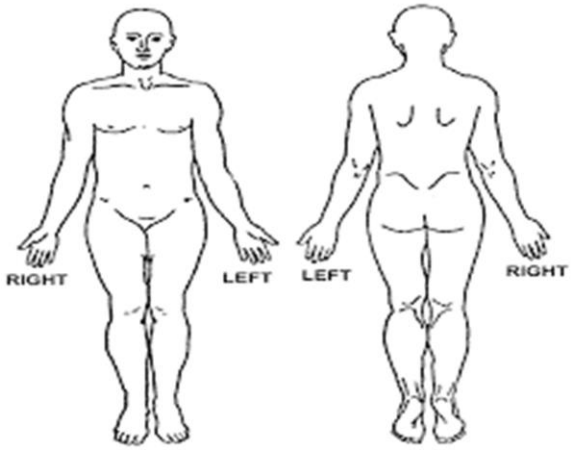
Please indicate if you have any of the following:

□ Yes □ No Aneurysm clip(s)
□ Yes □ No Cardiac pacemaker
□ Yes □ No Implanted cardioverter defibrillator (ICD)
□ Yes □ No Electronic implant or device
□ Yes □ No Magnetically-activated implant or device
□ Yes □ No Neurostimulator or bone stimulator
□ Yes □ No Brace, splint or other joint support
□ Yes □ No Internal electrodes or residual wires
□ Yes □ No Cochlear, otologic, or other ear implant
□ Yes □ No Insulin or other infusion pump
□ Yes □ No Morphine infusion pump
□ Yes □ No Penile prosthesis
□ Yes □ No Heart valve prosthesis
□ Yes □ No History of eye or retina surgery
□ Yes □ No Artificial or prosthetic limb
□ Yes □ No Abdominal aortic aneurysm stent graft
□ Yes □ No Shunt (spinal or intraventricular)
□ Yes □ No Radiation seeds or implants
□ Yes □ No Medication patch (Nicotine, Nitroglycerin)
□ Yes □ No Any metallic fragment or foreign body
□ Yes □ No Wire mesh implant
□ Yes □ No Breast tissue expander
□ Yes □ No Surgical staples, clips, or metallic sutures
□ Yes □ No Joint replacement (hip, knee, etc.)
□ Yes □ No Bone/joint pin, screw, nail, wire, plate, etc.
□ Yes □ No IUD
□ Yes □ No Dentures or partial plates
□ Yes □ No Body piercing jewelry
□ Yes □ No Hearing aid (Remove before entering
□ Yes □ No Breathing problem or motion disorder
□ Yes □ No Claustrophobia (Afraid of confined spaces)
□ Yes □ No **Have you ever been injured by any metallic object (e.g. bullet, shrapnel, BB, etc.)?**
□ Yes □ No **Have you ever had an eye injury involving a metallic object (e.g. metallic slivers, shavings, etc.)?**

IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove ALL metallic objects including cell phones, **ALL JEWELRY**, hearing aids, dentures, partial plates, keys, eyeglasses, hair pins, barrettes, body piercings, watches, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools. Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE YOU ENTER THE MRI SYSTEM ROOM. Lockers will be provided before entering the MRI Suite (Glasses, dental work, shoes can remain with you until you enter the room). ***For your safety, you will be asked to change into a gown.***

PLEASE MARK ON THE FIGURE BELOW THE LOCATION OF IMPLANTS OR METAL INSIDE OF OR ON YOUR BODY



Note: You may be advised to wear earplugs or other hearing protection during the MRI to prevent possible problems related to noise. MRI is generally a safe procedure. Qualified medical personnel will be present throughout procedure.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form; had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date: _____

If Form Completed By Someone Other than the Patient (Print name/Relationship):_____

MRI Technologist: _____

MRI CONTRAST FORM

SJRA
SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete
DOS: ____ / ____ / ____

PATIENT #: _____

PATIENT NAME: _____

DOB: _____ / _____ / _____ / AGE: _____ / SEX: _____

Your doctor has asked that your symptoms be evaluated with an MRI study with gadolinium intravenous contrast. Gadolinium contrast is given by injection into a vein and helps provide the radiologist with additional information that may not be available without intravenous contrast.

The gadolinium contrast agent you will receive 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. Minor and temporary reactions include pain at the injection site, nausea, headache, dizziness, itching, rash or hives. Rarely, a true allergic reaction may occur (including facial swelling, difficulty breathing, or low blood pressure) requiring treatment. The odd of an extremely severe reaction, including death, is very rare. There is also an extremely rare disease called Nephrogenic Systemic Fibrosis that has occurred in patients with kidney failure. As such, we screen at-risk patients by obtaining kidney function studies prior to contrast injection.

Your chances of a reaction may be increased if you have had a previous allergic reaction to gadolinium, are allergic to other drugs or foods, have asthma, or suffer from kidney disease. Please inform the MR technologist if any of these situations apply to you.

Please answer the questions below.

Please list all allergies: _____

□ Yes □ No - Do you have asthma?

□ Yes □ No - Do you have an allergy to CT (iodinated contrast) or MRI (gadolinium) contrast? (If yes, circle which one)
If yes, when and what happened? _____

□ Yes □ No - Have you ever had an anaphylactic reaction (severe allergic reaction where you had to be hospitalized)?
If yes, when and what happened?_____

Are you currently on dialysis?	□ Yes □ No	Have you ever had kidney disease or kidney cancer?	□ Yes □ No
Have you had a kidney transplant?	□ Yes □ No	Are you a diabetic on insulin or prescribed medication?	□ Yes □ No
Have you ever had kidney surgery?	□ Yes □ No	Do you have only one kidney?	□ Yes □ No

FOR WOMEN:

Are you breast feeding?	□ Yes □ No
Are you receiving hormone treatment?	□ Yes □ No

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form. By signing below I agree to gadolinium contrast injection.

Signature of Person Completing Form: _____ Date: _____

If Form Completed By Someone Other than the Patient (Print name): _____

Relationship: _____

TECHNOLOGIST USE ONLY

IV Contrast: _____ cc (Circle) Omniscan Multihance Other:_____

Comments: _____

_____

_____

_____ MRI Technologist_____

BREAST MRI EXAM

SJRA
SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete
DOS: ____ / ____ / ____

PATIENT #: _____
PATIENT NAME: _____
DOB: _____ / _____ / _____ / AGE: _____ / SEX: _____

Are you having the MRI to evaluate a specific problem with your breast?
☐ No, this is for screening only.
☐ Yes; if so, please explain: _____

Where and when was your last mammogram? Where: _____ When: _____
Results: _____
(*If you brought films with you, leave them with the technologist. Please call the office 48 hours following your study to arrange pickup. If you did not bring films, they may be requested for correlation with the MRI.)*

Have you had a recent breast ultrasound examination? Where: _____ When: _____
Results: _____

Have you ever had a breast biopsy (surgical biopsy or needle biopsy), or other breast surgery (including implants, reductions or reconstruction)**?**
☐ No
☐ Yes, Right Breast Date: _____ Results: _____
☐ Yes, Left Breast Date: _____ Results: _____

If you have breast implants, please specify date of surgery and type of implant (silicone, Saline, Double lumen, etc): When? _____ What type: _____

Have you ever had breast cancer?
☐ No
☐ Yes, Right Breast Date: _____ Treatment: ☐ Lumpectomy ☐ Radiation ☐ Chemo
☐ Yes, Left Breast Date: _____ Treatment: ☐ Lumpectomy ☐ Radiation ☐ Chemo

Have you had any other kind of cancer?

Has a family member had breast cancer?
☐ No ☐ Yes, which relative(s), at what age(s): _____

How many pregnancies have you had? _____ **Age at first pregnancy:** _____

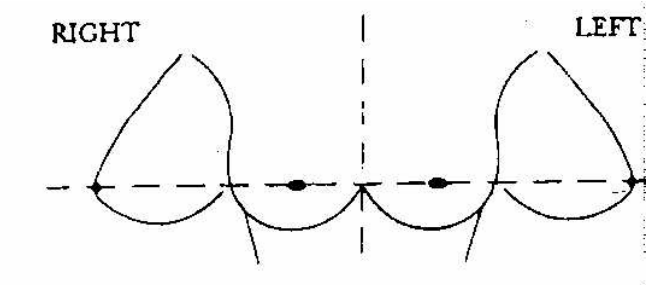
Are you (please check one): ☐ before menopause ☐ after Menopause

Last menstrual period was: _____ **Any chance you could be pregnant?** ☐ No ☐ Yes

Are you taking any type of hormones (including estrogen replacement or birth control pills)?
☐ No ☐ Yes, for how long? _____ What type? _____

Patient Signature: _____

TECHNOLOGIST: Please mark scars ### and lumps ●



PLACE VITAMIN E ON BREAST FOR LUMPS

SJRA
SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete
DOS: ____ / ____ / ____

PATIENT #: _____
PATIENT NAME: _____
DOB: _____ / _____ / _____ / AGE: _____ / SEX: _____

Patient Accompanied By: _____

CONSENT FOR INVASIVE RADIOGRAPHIC PROCEDURE(S)

I _____AUTHORIZE Dr. _____ and/or His/her associates and such assistants as may be selected by him/her to perform upon me (or the above named patient) the following Radiology procedures(s):

_____

_____

The Radiologist has adequately explained to me the medically significant risks and possible complications that are or may be associated with this procedure, and the alternatives, if any. I have has the opportunity to fully discuss these matters. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me about the results of the radiology procedure.

I certify that I have read and fully understand the above consent which has been preceded by an explanation by the Radiologist. I acknowledge and an satisfied that I have been adequately informed concerning material risks, possible complications and alternatives, if any, of this procedure and specifically consent to such.

_____ _____ AM / PM
Signature of Patient Date / Time

_____
Witness

In the event the above named patient is an un-emancipated minor, or is unable to sign for the following reason(s).

_____

_____

_____ _____ AM / PM
Signature of Patient Date / Time

_____
Witness