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.

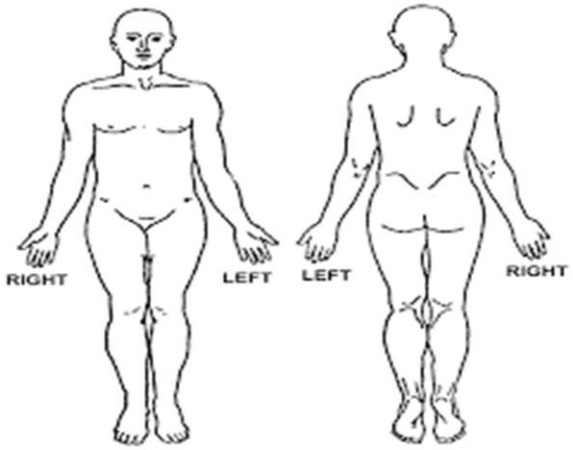
Please indicate if you have any of the following:

□ 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 more serious allergic reaction may occur (including facial swelling, difficulty breathing, or low blood pressure) requiring treatment. The odds of an extremely severe reaction, including death, are very rare.

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?_____

FOR WOMEN: Are you breast feeding? □ 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 you 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) Dotarem Multihance Other:_____

Comments:_____

_____MRI Technologist:_____

MRI NEURO HISTORY

SJRA
SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

Patient MUST Complete
DOS: ____ / ____ / ____

PATIENT #: _____

PATIENT NAME: _____

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

***** Please answer the following questions about your medical history to the best of your ability. Our Radiologists and staff will use the information you provide to select the most appropriate imaging techniques and to interpret the examination in order to best serve you! If you have any questions, please do not hesitate to ask. *****

Please describe the symptoms you are having that led to this test.
If applicable, please tell us where and which side (RIGHT/LEFT).

HEIGHT: WEIGHT:

Describe here: _____

_____

How long have you been having symptoms (days/weeks/months/years)? _____

□ Yes □ No - Was this related to injury/trauma? If yes, describe what happened. _____

_____

□ Yes □ No - Do you have a personal history of cancer? If yes, what type and when was it diagnosed? _____

_____

If yes, describe how your cancer was treated (radiation/chemo/surgery)? Please list approx dates of treatment/procedures

_____

Please list any other medical problems you have: _____

_____

Please list all surgeries you have had, along with approximate dates: _____

_____

Please list what/when/where you've had prior studies of the same body part (MRI/CT/XRays/US/Angio/Nuclear Med)?

_____

FOR WOMEN: Date of last menstrual period: _____ Are you post menopausal? □ Yes □ No
Are you experiencing a late menstrual period? □ Yes □ No Any chance that you are pregnant? □ Yes □ No
Are you taking any form of birth control? □ Yes □ No -- If yes, list: _____

TECHNOLOGIST USE ONLY

Comments: _____

_____

_____

_____ MRI Technologist: _____Ext:_____

I attest that the information on the form above, including technologist comments above, 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 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: _____