

IRVING ORTHOPEDICS & SPORTS MEDICINE

OPEN MRI

PATIENT HISTORY AND SCREENING FORM FOR MRI

DATE: ___ / ___ / ___ SEX: M F
PATIENT NAME: _____
PATIENT #: _____ DOB: ___ / ___ / ___ AGE: _____ WT: _____ HT: _____
PROCEDURE: _____
REFERRING PHYSICIAN: _____
REASON YOU ARE HERE FOR AN MRI TODAY? EXPLAIN YOUR MEDICAL PROBLEM IN DETAIL.
WHAT IS THE PROBLEM? WHERE IS THE PROBLEM? HOW LONG HAVE YOU HAD THIS PROBLEM?

HAVE YOU HAD A PREVIOUS EXAM RELATED TO THIS PROBLEM? YES NO
IF YES, EXPLAIN: _____

HAVE YOU TAKEN ANY MEDICATION / ALCOHOL TODAY TO RELAX YOU FOR THIS PROCEDURE?
 YES NO IF YES, WHAT? _____

DO YOU HAVE ANY OF THE FOLLOWING?

<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	HEART SURGERY/HEART VALVE/PACEMAKER. IF YES, EXPLAIN: _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	BRAIN SURGERY/BRAIN ANEURYSM CLIPS. IF YES, EXPLAIN: _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	SHUNTS/STENTS/INTRAVASCULAR COIL _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	EYE SURGERY/IMPLANTS _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	INJURY TO EYE INVOLVING METAL OR METAL SHAVINGS _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	PENILE PROSTHESIS _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	ORTHOPEDIC PINS, SCREWS, RODS, ETC. _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	NEUROSTIMULATOR/BIOSTIMULATOR _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	RADIATION THERAPY/CHEMO THERAPY _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	HISTORY OF CANCER OR TUMORS _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	PREVIOUS BACK SURGERY (NECK/BACK) _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	EAR SURGERY/COCHLEAR IMPLANTS/HEARING AIDS _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	VASCULAR ACCESS PORT _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	DIAPHRAGM/TUD/PESSARY _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	METAL MESH IMPLANTS/WIRE SUTURES/WIRE STAPLES/INTERNAL ELECTRODES _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	ANY ELECTRICAL, MECHANICAL, OR MAGNETIC IMPLANTS. TYPE: _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	IMPLANTED DRUG INFUSION PUMP/INSULIN PUMP _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	IMPLANTED CARDIAC DEFIBRILLATOR _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	PACING WIRES, SWANN GANZ CATHETER _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	ARE YOU PREGNANT? LAST MENSTRUAL PERIOD: _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	TATTOO'S/PERMANENT MAKE-UP/ BODY PIERCINGS _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	DENTURES, PARTIALS, OR DENTAL IMPLANTS: _____
<input type="checkbox"/>	YES	<input type="checkbox"/>	NO	GUNSHOTS WOUNDS, SHRAPNEL, BB'S: _____

LIST ANY DRUG ALLERGIES: _____

LIST PREVIOUS SURGERIES: _____

MEDICATIONS PRESENTLY TAKING: _____

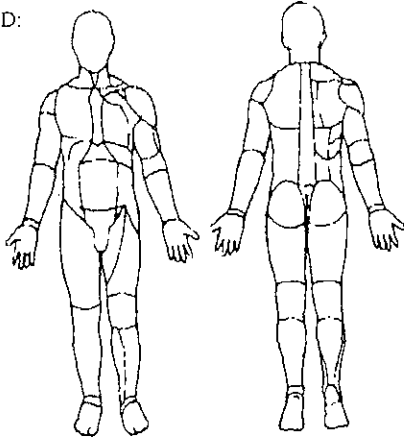
MRI CONTRAST HISTORY:

NOT APPLICABLE FOR THIS EXAM

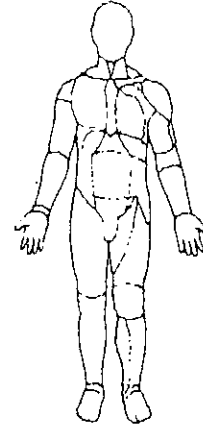
ANY PERSONAL HISTORY OF:

<input type="checkbox"/> YES	<input type="checkbox"/> NO	SEIZURES/ HEADACHES/DIZZINESS	<input type="checkbox"/> YES	<input type="checkbox"/> NO	STROKE
<input type="checkbox"/> YES	<input type="checkbox"/> NO	ALLERGIC RESPIRATORY DISEASE	<input type="checkbox"/> YES	<input type="checkbox"/> NO	KIDNEY/BLADDER DISEASE
<input type="checkbox"/> YES	<input type="checkbox"/> NO	BREAST FEEDING	<input type="checkbox"/> YES	<input type="checkbox"/> NO	ASTHMA
<input type="checkbox"/> YES	<input type="checkbox"/> NO	BLOOD DISORDER/SICKLE CELL ANEMIA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	LIVER DISORDER
<input type="checkbox"/> YES	<input type="checkbox"/> NO	ARE YOU BREAST FEEDING AT THIS TIME?			
<input type="checkbox"/> YES	<input type="checkbox"/> NO	REACTION TO MRI CONTRAST IN THE PAST. IF YES, EXPLAIN:			_____

DRAW ON THE FIGURES BELOW WHERE THE PAIN OR SYMPTOMS ARE LOCATED:



PLEASE DRAW ON THE FIGURE BELOW THE LOCATION OF ANY METAL IN YOUR (OR THE MINOR'S) BODY:



ACKNOWLEDGEMENT:

I HAVE ANSWERED THESE QUESTIONS TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THE INFORMATION PRESENTED TO ME. I HAVE ALSO INFORMED THE TECHNOLOGIST THAT I AM NOT PREGNANT AT THIS TIME.

PATIENT /PARENT/LEGAL GUARDIAN SIGNATURE

TECHNOLOGIST/WITNESS SIGNATURE

____ / ____ / ____
DATE

FOR CLINICIAN USE ONLY

PATIENT EDUCATION: VERBAL BROCHURE VIDEO IDENTIFY: _____

WRITTEN DISCHARGED INSTRUCTIONS: YES NO FORM #: _____

NOT APPLICABLE FOR THIS EXAM

PROHANCE
CC OF MAGNEVIST WITH A _____ @ _____ X _____ BY _____
OMNISCAN Ga & TYPE TIME # OF PUNCTURES SIGNATURE

IN _____ LOT # _____ EXPIRATION DATE: ____ / ____ / ____

PHYSICIAN PROVIDING CONTRAST COVERAGE: _____

CONTRAST REACTION: YES NO EXPLAIN: _____

IF ADDITIONAL SPACE IS NEEDED FOR DOCUMENTATION USE PATIENT NOTES FORM

DISCHARGED INSTRUCTIONS FOR CONTRAST REACTION GIVEN? YES NO FORM # _____

DISCHARGED INSTRUCTIONS FOR CONTRAST EXTRAVASATION GIVEN? YES NO FORM # _____

INFORMED CONSENT FOR MRI, WITH OR WITHOUT CONTRAST INJECTION

PATIENT NAME _____ PATIENT NUMBER _____

TO THE PATIENT: YOU HAVE THE RIGHT TO BE INFORMED ABOUT YOUR CONDITION AND THE RECOMMENDED SURGICAL, MEDICAL, OR DIAGNOSTIC PROCEDURE TO BE USED SO THAT YOU MAY MAKE THE DECISION WHETHER OR NOT TO UNDERGO THE PROCEDURE AFTER KNOWING THE RISKS AND HAZARDS INVOLVED. THIS DISCLOSURE IS NOT MEANT TO SCARE OR ALARM YOU. IT IS SO THAT YOU MAY CHOOSE TO GIVE OR WITHHOLD YOUR CONSENT TO THE PROCEDURE.

IF YOU ARE PREGNANT OR THINK THAT YOU MAY BE PREGNANT, PLEASE INFORM THE CENTER PERSONNEL AT ONCE. IT IS VERY IMPORTANT THAT YOU INFORM THE TECHNOLOGIST IF YOU HAVE HEART VALVES, A PACEMAKER, ANEURYSM CLIPS OR OTHER IMPLANTED METALLIC OR ELECTRICAL DEVICES.

YOUR PHYSICIAN HAS REQUESTED THAT WE PERFORM A MAGNETIC RESONANCE IMAGING (MRI) EXAMINATION TO OBTAIN ADDITIONAL INFORMATION; MRI USES A MAGNETIC FIELD AND RADIO WAVES TO PRODUCE AN IMAGE OF THE INTERNAL BODY PARTS BEING EXAMINED. MRI IS PAINLESS, AND DOES NOT USE X-RAYS OR RADIATION. THE ONLY DISCOMFORT INVOLVED MAY HAVE TO LIE QUIETLY IN A CONFINED SPACE DURING THE STUDY. BECAUSE THE MRI IS A DIAGNOSTIC PROCEDURE, IT PROVIDES INFORMATION THAT MAY AID YOUR PHYSICIAN IN DIAGNOSING AND TREATING YOUR MEDICAL CONDITION. WITHOUT THE MRI SCAN, ACCURATE DIAGNOSIS AND PROPER TREATMENT MAY BE DELAYED.

AS PART OF YOUR MRI, A CONTRAST AGENT MAY BE INJECTED INTO YOUR VEIN IN ORDER TO PRODUCE BETTER IMAGES OF THE PART OF YOUR BODY THAT IS BEING EXAMINED. THE MRI PROCEDURE MAY BE CONDUCTED WITHOUT THE INJECTION OF THE CONTRAST AGENT, BUT THE IMAGES MAY NOT BE AS HELPFUL TO THE RADIOLOGIST AND YOUR PHYSICIAN. IF YOU WISH TO REFUSE THE CONTRAST INJECTION, INFORM THE TECHNOLOGIST AND THE MRI WILL BE CONDUCTED WITHOUT THE CONTRAST AGENT.

POTENTIAL RISKS – THE FOLLOWING COMPLICATIONS ARE POSSIBLE: ANYTIME AN INJECTION IS GIVEN, THERE IS POTENTIAL FOR PAIN, BLEEDING, BRUISING OR SWELLING AT THE INJECTION SITE. MRI EXAMS REQUIRING CONTRAST MAY RESULT IN MILD HEADACHE, NAUSEA, AND ITCHING OR OTHER VAGUE SYMPTOMS FOR A SHORT TIME AFTER THE INJECTION. ADDITIONAL ALLERGIC REACTIONS IN RESPONSE TO THE CONTRAST AGENT MAY INCLUDE HIVES, SHORTNESS OF BREATH OR DIFFICULTY IN SWALLOWING. THERE HAVE BEEN RARE INSTANCES OF DEATH AFTER THE ADMINISTRATION OF THE CONTRAST AGENT. IT IS VERY IMPORTANT THAT YOU INFORM THE TECHNOLOGIST IF YOU EXPERIENCE ANY OF THE CONDITIONS MENTIONED IN THIS FORM.

NOTE TO PATIENTS: IF YOU HAVE PREVIOUSLY HAD A REACTION TO A CONTRAST INJECTION SUCH AS HIVES, SEVERE ITCHING, SHORTNESS OF BREATH AND/OR ANY SIGNIFICANT REACTION REQUIRING HOSPITALIZATION, A HISTORY OF ASTHMA OR OTHER ALLERGIC CONDITIONS, ANY HISTORY OF ANEMIA SICKLE CELL ANEMIA OR KIDNEY DISORDER ARE PREGNANT OR BREAST-FEEDING, YOU MUST INFORM THE TECHNOLOGIST. THE SAFETY OF CONTRAST FOR CHILDREN UNDER THE AGE OF 2 HAS NOT BEEN ESTABLISHED.

THERE MAY BE OTHER IMAGING ALTERNATIVES, HOWEVER YOUR PHYSICIAN BELIEVES THE MRI TO BE THE BEST DIAGNOSTIC TEST FOR YOU, CONSIDERING YOUR SYMPTOMS AND CONDITION. THE BENEFIT OF THIS EXAM IS TO ASSIST YOUR PHYSICIAN WITH A DIAGNOSIS.

I (WE) CERTIFY THIS FORM HAS BEEN FULLY EXPLAINED TO ME, THAT I (WE) HAVE READ IT OR HAVE HAD IT READ TO ME, THAT THE BLANK SPACES HAVE BEEN FILLED IN, AND THAT I (WE) UNDERSTAND ITS CONTENTS.

I (WE) HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS ABOUT MY CONDITION, ALTERNATIVE FORMS OF ANESTHESIA AND TREATMENT, THE PROCEDURES TO BE USED, AND THE RISKS AND HAZARDS INVOLVED, AND I (WE) HAVE SUFFICIENT INFORMATION TO GIVE THIS INFORMED CONSENT.

X _____ DATE _____ TIME _____
(PATIENT/PARENT/LEGAL GARDIAN SIGNATURE)

X _____ DATE _____ TIME _____
(WITNESS SIGNATURE)