# MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date _____/_____/_____ Patient Number _____

Name _____ Age _____ Height _____ Weight _____
Last name First name Middle Initial

Date of Birth _____/_____/_____ Male ❒ Female ❒ Body Part to be Examined _____
month day year

Address _____ Telephone (home) (_____) _____-_____

City _____ Telephone (work) (_____) _____-_____

State _____ Zip Code _____

Reason for MRI and/or Symptoms _____

Referring Physician _____ Telephone (_____) _____-_____

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? ❒ No ❒ Yes
   If yes, please indicate the date and type of surgery:
   Date _____/_____/_____ Type of surgery _____
   Date _____/_____/_____ Type of surgery _____
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ❒No ❒ Yes

| If yes, please list: | Body part | Date | Facility |
|---|---|---|---|
| MRI | _____ | _____/_____/_____ | _____ |
| CT/CAT Scan | _____ | _____/_____/_____ | _____ |
| X-Ray | _____ | _____/_____/_____ | _____ |
| Ultrasound | _____ | _____/_____/_____ | _____ |
| Nuclear Medicine | _____ | _____/_____/_____ | _____ |
| Other_____ | _____ | _____/_____/_____ | _____ |

3. Have you experienced any problem related to a previous MRI examination or MR procedure? ❒ No ❒ Yes
   If yes, please describe: _____
4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)? ❒ No ❒ Yes
   If yes, please describe: _____
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ❒ No ❒ Yes
   If yes, please describe: _____
6. Are you currently taking or have you recently taken any medication or drug? ❒ No ❒ Yes
   If yes, please list:_____
7. Are you allergic to any medication? ❒ No ❒ Yes
   If yes, please list:_____
8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ❒ No ❒ Yes
9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease or seizures? No ❒ Yes
   If yes, please describe: _____

**For female patients:**

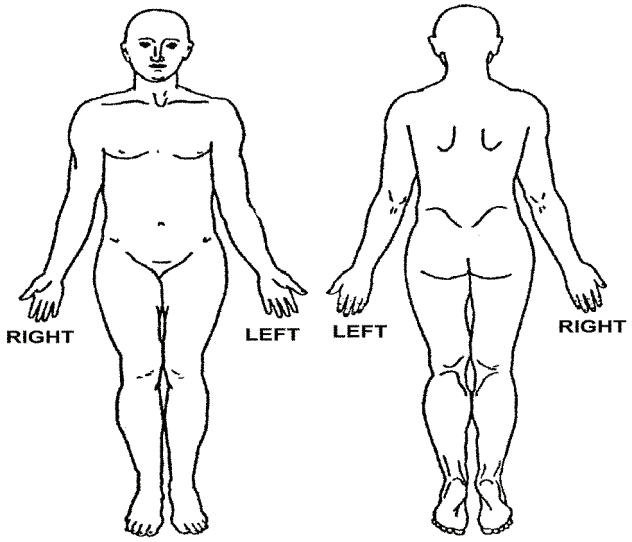
10. Date of last menstrual period:_____/_____/_____ Post menopausal? ❒ No ❒ Yes
11. Are you pregnant or experiencing a late menstrual period? ❒ No ❒ Yes
12. Are you taking oral contraceptives or receiving hormonal treatment? ❒ No ❒ Yes
13. Are you taking any type of fertility medication or having fertility treatments? ❒ No ❒ Yes
    If yes, please describe: _____
14. Are you currently breastfeeding? ❒ No ❒ Yes

**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system 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 Neurostimulation system
❒ Yes ❒ No Spinal cord stimulator
❒ Yes ❒ No Internal electrodes or wires
❒ Yes ❒ No Bone growth/bone fusion stimulator
❒ Yes ❒ No Cochlear, otologic, or other ear implant
❒ Yes ❒ No Insulin or other infusion pump
❒ Yes ❒ No Implanted drug infusion device
❒ Yes ❒ No Any type of prosthesis (eye, penile, etc.)
❒ Yes ❒ No Heart valve prosthesis
❒ Yes ❒ No Eyelid spring or wire
❒ Yes ❒ No Artificial or prosthetic limb
❒ Yes ❒ No Metallic stent, filter, or coil
❒ Yes ❒ No Shunt (spinal or intraventricular)
❒ Yes ❒ No Vascular access port and/or catheter
❒ Yes ❒ No Radiation seeds or implants
❒ Yes ❒ No Swan-Ganz or thermodilution catheter
❒ Yes ❒ No Medication patch (Nicotine, Nitroglycerine)
❒ Yes ❒ No Any metallic fragment or foreign body
❒ Yes ❒ No Wire mesh implant
❒ Yes ❒ No Tissue expander (e.g., breast)
❒ 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, diaphragm, or pessary
❒ Yes ❒ No Dentures or partial plates
❒ Yes ❒ No Tattoo or permanent makeup
❒ Yes ❒ No Body piercing jewelry
❒ Yes ❒ No Hearing aid
*(Remove before entering MR system room)*
❒ Yes ❒ No Other implant _____
❒ Yes ❒ No Breathing problem or motion disorder
❒ Yes ❒ No Claustrophobia

**Please mark on the figure(s) below the location of any implant or metal inside of or on your body.**




## IMPORTANT INSTRUCTIONS

**Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.**

**Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.**

**NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.**

I attest that the above information is correct to the best of my knowledge. I 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 _____/_____/_____
Signature

Form Completed By: ❒ Patient ❒ Relative ❒ Nurse _____ _____
Print name Relationship to patient

Form Information Reviewed By: _____ _____
Print name Signature

❒ MRI Technologist ❒ Nurse ❒ Radiologist ❒ Other_____

*****TO ALL PATIENTS: PLEASE BE AWARE*****

***ALL APPOINTMENTS MUST BE CONFIRMED BY 5PM THE DAY BEFORE YOUR SCHEDULED APPOINTMENT OR THEY ARE CONSIDERED CANCELED. PLEASE BE ADVISED THAT THERE IS A $250.00 CANCELLATION FEE FOR ALL APPOINTMENTS WHICH YOU NEGLECT TO CANCEL 24HOURS IN ADVANCE.***

Neurological Associates of Long Island, PC is notifying you of your right to choose another facility for diagnostic testing purposes. If you are interested in going to another facility, a list of facilities in your area is available upon your request.

**Breast Feeding Mothers:** Review of literature by the American College of Radiology shows no evidence to suggest that oral ingestion by an infant of the tiny amount of gadolinium contrast medium excreted into breast milk would cause toxic effects. However, if you are still concerned please follow these guidelines for expressing milk: You may abstain from breast feeding for 24 hours with active expression and discarding of breast milk from both breasts during the 24 hour period. In anticipation of this, you may wish to use a breast pump to obtain milk before the contrast study to feed the infant during the 24-hour period following the examination.

****Please be advised that if you are bringing in outside imaging for comparison, we will contact you to pick up your images. This office will not mail out outside images. Any discs/films left in our possession after 2 weeks of being contacted will be destroyed.****

## *MRI PREPARATION:*

- Please complete the accompanying forms prior to appointment
- No caffeine for at least three hours prior to the exam
- Do not wear any jewelry
- Please wear clothing free of any metal, snaps, zippers, etc.
- You may take your medication and eat normally
- **For contrast-enhanced studies: Please consume at least 8-10 eight ounce glasses of water the day prior to the exam and 2-3 eight ounce glasses of water 2 hours before the test**

**BRAIN MRI/MRA**

* Please do not wear any eye makeup

**BONY PELVIS/LUMBAR PLEXUS**

* No food 6 hours prior to appointment time. Clear liquid is permitted

**I have read and I understand the above listed information**.

**Name (Printed):** _____

**Patient Signature**_____ Date: _____

# Physicians' Open MRI

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www.neuroli.com

## CONSENT FOR MRI CONTRAST INJECTION

Your doctor has scheduled you for an MRI examination that requires an injection of a contrast agent into your bloodstream. MR contrast agents currently contain a compound called gadolinium, a non-iodine-based material as their main ingredient. The contrast agent (also termed contrast media or contrast material) shows up white on MRI images and helps the radiologist interpret the MRI scans.

The contrast media is given through a small needle placed into a vein, usually on the inside of your elbow or on the back of your hand. Contrast media is considered to be quite safe. However, any injection carries a slight risk of harm including injury to a nerve, artery or vein, infection or reaction to the material being injected. The incidence of allergic reactions to gadolinium-based contrast agents is extremely rare. Patients with **Sickle Cell Anemia** and **Kidney Disease** should **not** have gadolinium. You may experience headache with other possible adverse reactions, which are much less likely.

Your decision to receive this contrast agent is entirely voluntary.

If you have any questions, please ask the MRI technologist or your doctor.

I have read the above information and have had my questions answered.

SIGNATURE: _____

PRINT NAME: _____

DATE: _____