Name:
DOB:
Chart:
Age:
Date:

MRI DATA SHEET / CONSENT FOR DIAGNOSTIC TESTING

Ordering Provider: _____ Patient Weight: _____ Patient Sex: _____

What kind of problems are you having related to today's exam? _____

	Yes	No	
Do you have any drug allergies?			List:
Do you have a personal history of any type of cancer?			What kind?
Are you pregnant, think you might be pregnant, or are you currently breastfeeding?			**If yes, please notify MRI staff immediately.**
Have you ever had an MRI on the area being examined today?			Date: Facility:
Have you ever had a reaction to MRI or CT contrast?			**If yes, please notify MRI staff immediately.**
Have you ever had an injury to the eye involving a metallic object or metallic slivers?			**If yes, please notify MRI staff immediately.**
Have you ever had surgery on the area being examined today?			Date: Type of surgery:

List ALL surgeries: _____

Please check if you have any of the following:

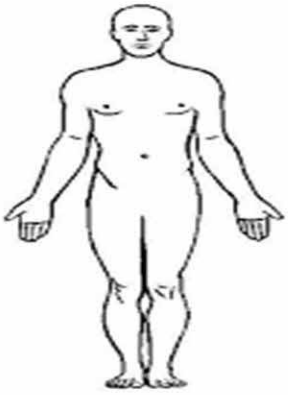
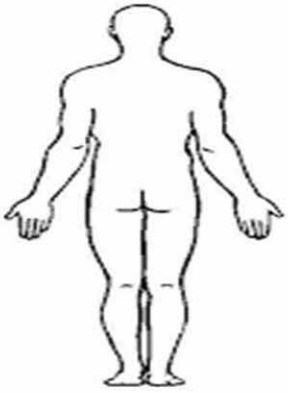
	Yes	No		Yes	No
Cardiac Pacemaker			Vascular access port?		
If yes, please notify MRI staff immediately.			Intracranial aneurysm clip?		
Cardiac Stent or any type of stent?			Any type of implant held in place by		
Cardiac pacer or lead wire?			magnet? Dentures?		
Heart valve prosthesis?			Intraventricular shunt?		
Any type of intravascular coil, filter, or stent?			Hearing aid?		
(IVC filter, Gianturco coil, etc.)			Orbital/eye prosthesis?		
Implanted insulin pump?			Artificial limb or joint?		
Any type of electronic or mechanical implant?			Wire mesh?		
Type: _____			Body piercing or tattooed eyeliner?		
Penile implant?			Any type of implanted orthopedic item		
Implanted drug infusion device?			such as pins, screws, nails, etc?		
Make or Model: _____			Type: _____		
Any type of internal electrode, including			Are you wearing a transdermal patch?		
cochlear (ear) implant?			Any other implanted item?		
Claustrophobic:			Type: _____		
*If yes, medication must be ordered by your provider prior to your MRI appointment.			Pessary, IUD, etc?		

Name:
DOB:
Chart:
Age:
Date:

MRI DATA SHEET / CONSENT FOR DIAGNOSTIC TESTING pg. 2

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI procedure. **DO NOT ENTER** the MRI system room or MRI environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist BEFORE entering the MRI room. **The MRI system magnet is ALWAYS on.**

Please mark on the figure(s) the location of any IMPLANT OR METAL inside of or on your body.

Right  Left  Right

IMPORTANT INSTRUCTIONS: Before entering the MRI 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.

* It is also important to avoid skin-to-skin contact during the MRI, due to possible tissue heating. Therefore, it is important to stay in the position that the technologist puts you in.
* Please consult the MRI Technologist if you have a question or concern BEFORE you enter the MRI system room.

NOTE: You will be advised or required to wear earplugs or other hearing protection during the MRI 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 MRI procedure that I am about to undergo.

Patient Signature: _____ Date: _____

Patient Representative: _____ Relation to Patient: _____

Technologist Signature: _____ Date: _____