Bartlett Regional Hospital

MRI Safety Questionnaire

Name: ________________________________ **DOB :** ___________ **Daytime Phone:** ______________

Exam____ **Date**_____________ **Time**_____________

Height______ **Weight**_______ **Age** ______ **Ordering Physician** _____________________________

Creatinine: ______ **GFR:** _____ **Date:** _________ **Revised 10/11/21**

Yes	No	Do you have any of the following:
		Please list ALL prior surgeries or medical procedures.
		Any previous imaging (of exam you are having today)? If yes, please list type of imaging/facility.
		Medication allergies? If yes, please list here.
		Claustrophobia? Will you have sedation? (You will need someone to drive you if sedated.)
		Do you have considerable pain that would make it difficult to lie on your back for 30 minutes or longer? Pain/Sedation Meds must be prescribed by your provider prior to the appointment.
		Cardiac pacemaker, pacing wires or internal defibrillator? Any abandoned leads/wires?
		Aneurysm clips?
		Neuro stimulator or bio stimulator?
		Artificial heart valve?
		Hearing aids or inner ear implants? If yes, can they be removed?
		Any IV access port (Port-a-cath, PICC line, Hickman, Broviac)?
		Medication pump or infusion pump?
		Any electronic, mechanical or magnetic implant?
		Intravascular coils, filters or stents?
		Joint replacements or artificial limbs?
		Surgical clips, staples, wires, rods, pins, plates or screws, etc?
		Body piercing? If yes, all piercings **MUST** be removed.
		Tattoos? If yes, were they done professionally?
		Injury from metal object to your eyes or any part of your body (slivers, shavings, BB, shrapnel, bullet)?
		Dentures or removable braces?
		Medication patches?
		Are you diabetic? And/or do you have a CGM sensor? **CGM must be removed.**
		Are you pregnant or experiencing a late menstrual period?
		IUD, diaphragm, bladder sling or pessary?
		Breast tissue expanders?
		Penile prosthesis?
		Personal history of cancer? If yes, what type and year of diagnosis?
		Any hair accessories (extensions, weaves, wig, bobby pin, barrettes, clips)?
		Magnetic cosmetics (i.e. magnetic eyelashes, magnetic nail polish)?
		Artificial eye, eyelid spring, or eyelid weight?
		Any other implant(s)?

Comments:

Patient or Family Member Signature: **X**

Technologist or Nurse Signature:

Bartlett
Regional Hospital

Name: ______________________________________

MRN: ______________________ **DOB:** _________

Consent for MRI Contrast

Your physician has ordered an MRI examination for you. During the exam we may need to give you an injection of contrast material called Gadolinium. Contrast isn't used with every exam but there are times that we do need it to help us get a better look at the structures we are imaging. This also helps the Radiologist give a more accurate reading of the exam.

Any time there is an injection of material into the body, there is the possibility of a reaction. The reaction could be very minor such as hives, nausea or headaches, or more severe such as difficulty breathing. The incidence of severe reactions (including death) with this contrast is less than 1%.

There are some health problems that can be a contraindication for receiving contrast. Please circle YES or NO if you have any of the following conditions:

YES **NO** Kidney or Liver Failure
YES **NO** Nephrogenic Systemic Fibrosis
YES **NO** Pregnant
YES **NO** Nursing

Drink 6 to 8 glasses of water over the next 24 hours.

I have read and understand the use of contrast material for this MRI exam and I give my permission to use contrast during my examination.

X_____________________________________ _____________________________________
Patient **Parent or Guardian**

_____________________________________ Date _________________________________
Technologist

I understand that an injection of contrast material will help the Radiologist give a better diagnosis of my exam but at this time **I DO NOT** want the contrast given to me.

X_____________________________________ _____________________________________
Patient **Parent or Guardian**

Contrast Brand: **Gadavist** _________mls Lot_______________ Expiration _____________

IV Site ___________________ Size ________ Time ______ Technologist ________________

No IV Problems ____ No Contrast Reaction ____ Cath Removed ____ Cath Left In ____

Tech Notes/Comments: ____

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