Whitman Hospital and Medical Center
MRI Experience

Please tell us about yourself and how we can help you today.

First Name:		Middle Initial:		Weight:		Height:	
Last Name:				Birthdate:			

**The following items can interfere with MRI. For your safety, please answer completely.*

Yes	No	Do you have a **pacemaker or defibrillator?**
Yes	No	Have you ever had brain surgery/**aneurysm coil or clips**?
Yes	No	Have you ever had GI surgery where they used a **Resolution Clip?**
Yes	No	**Medication/drug/insulin pump**?
Yes	No	Ear or eye surgery, **cochlear implant, etc.**?
Yes	No	TENS unit/neurostimulator/biostimulator?
Yes	No	Breast tissue expander?
Yes	No	Shunts/stents/intravascular coils?
Yes	No	Heart surgery/heart valve?
Yes	No	Shrapnel or metal fragments in body?
Yes	No	Electrical, magnetic, or mechanical implants or devices?
Yes	No	Artificial joint or prosthesis?
Yes	No	Are you, or could you be, pregnant?
Yes	No	Are you wearing any type of medication patch?
Yes	No	Have you ever worked with metal or had metal in your eyes?
Yes	No	Any tattoos or permanent makeup?
Yes	No	Do you have acute renal insufficiency, diabetes, or renal disease?
Yes	No	Any medication allergies? If so, please list them here.
Yes	No	Any history of allergic reaction to contrast dye? CT, MRI, or x-ray dye?
Yes	No	Do you have anything removable in your mouth? Denture, partials, etc.?
Yes	No	Do you wear hearing aids?
Yes	No	Do you have any hair accessories, a wig, or hair extensions?

Please list or comment on any other implanted device or metal you may have in your body:

Existing Conditions? *Please circle all that apply.*	Heart	Diabetes	Stroke	Cancer	Tumor	Kidney/ Dialysis	Asthma
Previous Surgeries? *Please circle all that apply.*	Brain		Spine		Joint		Abdomen

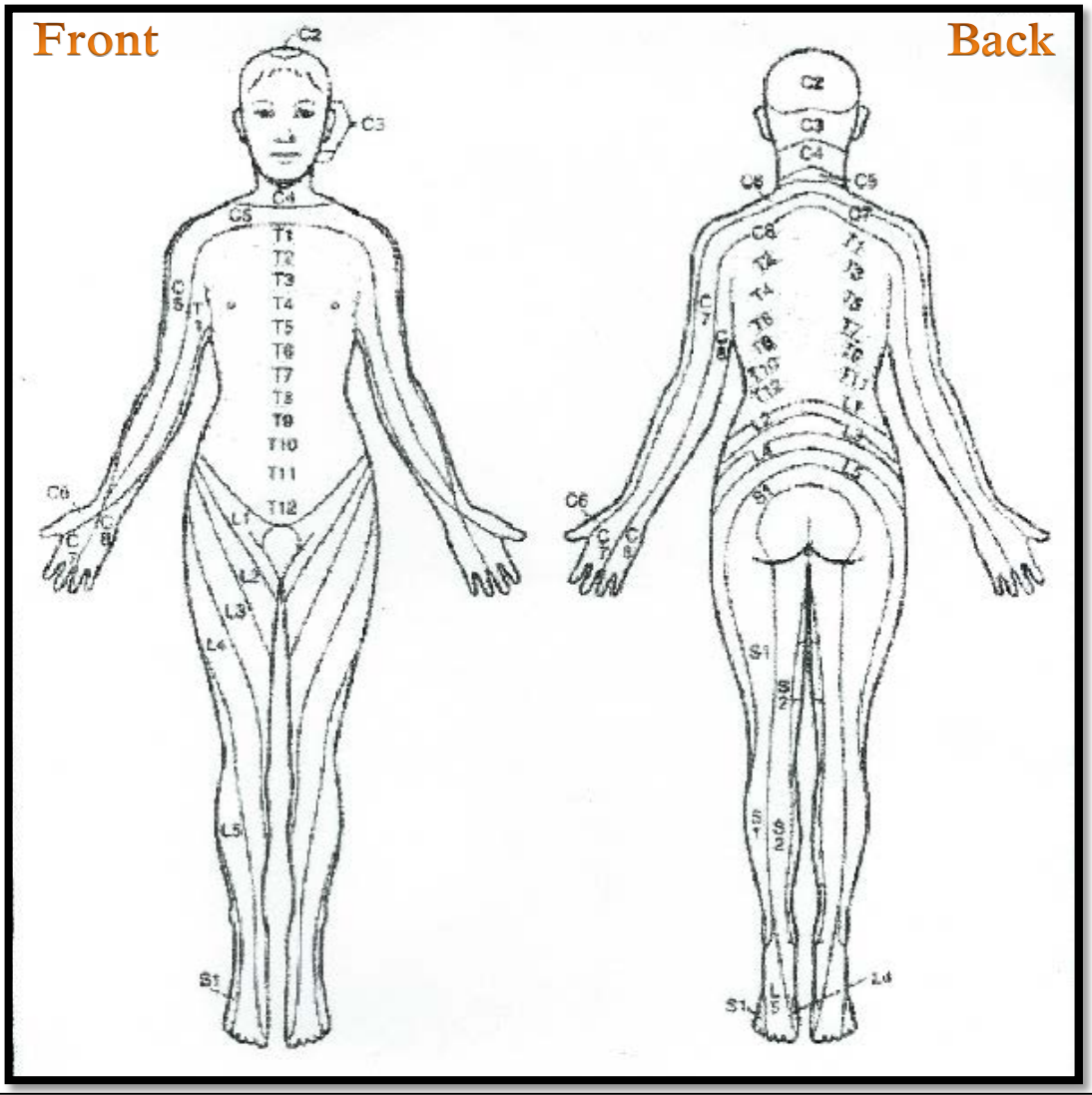
Your MRI exam may involve an IV injection of a contrast agent containing gadolinium. Although gadolinium contrast agents have been used safely in millions of patients, minor reactions (headache, nausea, hives) can occur. There is less than 1% risk of more serious or life-threatening reactions. **Do you consent to the IV contrast? (circle Yes or No)** Yes No

CONSENT: I have informed the technologist that I **do not have any metallic devices** (such as a pacemaker, implant, cerebral aneurysm clips, etc.) in my body or metallic foreign bodies in my eyes. I have answered all the 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.

Signature of Patient or Guardian _____ Date: _____

**Please provide further detail of the location/nature of your symptoms here:*

Please shade in the exact areas where you are experiencing symptoms, if possible.



Imaging Department Notes (to be entered by technologist only):

Technologist's Signature _____ **Date** _____

Creatinine _____ GFR _____ Date _____ Contrast _____ Amount _____

Lot # _____ Expiration Date _____