

## PATIENT DISCLOSURE AND INFORMED CONSENT - MRI

**Patient Name** \_\_\_\_\_ **Weight** \_\_\_\_\_ **MR#** \_\_\_\_\_

Your Doctor has requested that you have a Magnetic Resonance Imaging (MRI) examination to aid in your medical diagnosis. It is anticipated that you will benefit from this procedure, as this diagnostic imaging device may offer diagnostic information not available from other techniques.

### PLEASE READ AND CIRCLE YES OR NO TO THE FOLLOWING QUESTIONS:

Do you have a pacemaker?	Yes	No	Have you had any surgeries? If yes, when & what?	Yes	No
Have you ever had brain surgery?	Yes	No	_____		
Have you ever had spine surgery?	Yes	No	_____		
Do you have aneurysm clips, stents, coils, or filters in your blood vessels?	Yes	No	_____		
Have you ever had ear surgery or implants?	Yes	No	_____		
Have you ever had eye surgery or implants?	Yes	No	_____		
Are you wearing a hearing aid?	Yes	No	Date of last menstrual period	____/____/____	
Are you wearing a wig or hairpiece?	Yes	No	Do you have a war injury or gunshot wound?	Yes	No
Are you wearing metallic dental appliances?	Yes	No	Have you ever gotten metal fragments in your eyes from welding or grinding?	Yes	No
Do you have a history of:			Do you have any implanted devices such as electrodes, Neurostimulators, heart valves, orthopaedic implants, shunts, infusion pump, or prosthetic appliances?	Yes	No
Heart disease?	Yes	No	Is there any possibility you are pregnant?	Yes	No
Kidney disease?	Yes	No	Are you nursing an infant?	Yes	No
Kidney failure?	Yes	No	Are you wearing an IUD?	Yes	No
Cancer?	Yes	No	Do you have any concealed body piercing?	Yes	No
Diabetes?	Yes	No	Are you wearing magnetic false eyelashes?	Yes	No
High blood pressure?	Yes	No	Have you ever had radiation therapy?	Yes	No
Allergies?	Yes	No	Have you ever had a contrast injection with any adverse effect?	Yes	No
Are you on dialysis?	Yes	No	Do you have seizures?	Yes	No
Any other medical problems?	Yes	No			
<i>If yes, describe:</i>					

### **CONTRAINDICATIONS:**

Since MRI uses an electromagnetic field, **you cannot undergo this procedure if you have any of the following:** Cardiac pacemaker; cochlear implant; neurostimulators; metal fragments in the eye; implanted drug infusion pump (Medtronic OK); or aneurysm clip implanted in the brain.

\*Please inform us if you have any other implants not mentioned\*

### **PREGNANCY:**

The FDA has not established any criteria under which a pregnant woman may be scanned. Therefore, it is the policy of this facility that MR Imaging not be routinely performed on women with known or suspected pregnancy.

### **CONTRAST:**

Your Doctor may have requested that your exam be performed with intravenous contrast media (Dotarem) if necessary during the MRI exam. Dotarem injection is FDA approved and indicated for use with MRI examinations. Although Dotarem is very safe and allergic reactions are extremely rare, the possibility of an allergic reaction does exist. In addition, related complications such as pain or swelling at the sight of injection or phlebitis, although rare, are possible. The purpose, benefits and complications of the contrast procedure will be explained to your satisfaction before any injection takes place. A basic kidney function test will be performed if you have a history of kidney disease or kidney failure.

I confirm that the information I provided is complete and accurate to the best of my knowledge. I have read, understand, and hereby consent to this MRI examination.

\_\_\_\_\_  
Patient Signature / Parent or Guardian if Patient is a Minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date