

Client History and MRI Screening

Department of Diagnostic Imaging

HRN:	Site:	DOB: (yyyy/mm/dd)	
Last Name:	First and Additional Names:		
PHN:	Gender:	Age In Years:	
Admitting Physician:	Encounter #:		
Address: (Street, City, Province, Postal Code)			
Telephone Number:			
Date of Admission: (yyyy/mm/dd)	Family Physician:		
Client Weight:	Client Height:	Date:	Client ID#:

Do You Have...

	Yes	No	Unsure	Explain
Aneurysm clip(s), any type				
Any IV access Port, type				
Any type of coil, filter or stent in blood vessels?				
Any type of implant held in place by a magnet?				
Artificial Heart Valves?				
Artificial limb or joint, any orthopedic item (ie pins, rods, screws, clips, wires, etc.) Location?				
Body Piercing (other than earrings)? Location?				
Breast Implants / Tissue expanders?				
Cardiac (Heart) Pacemaker and wires?				
Cerebral Intra-Ventricular shunt? Type?				
Cochlear implant or other ear implant/hearing aid?				
Dentures, retainers, braces, magnetic implants or any other removable dental items?				
Diaphragm / IUD/ Pessary?				
Electrical stimulator for nerves or bones? Type?				
Implanted cardiac defibrillator?				
Implanted Electrodes, Pumps or Catheters?				

We do not promise a pain-free existence, but we do strive to improve our client's function and help them manage their pain.

	Yes	No	Unsure	Explain
Lens implant or cataract surgery				
Medication patch/dressing (ie: Nitroglycerin or Nicotine)				
Metal in your eyes (at any time in your life)?				
Neuro-Stimulators?				
Orbital/eye prosthesis/eyelid springs?				
Penile Prosthesis?				
Renal shunt?				
Shrapnel, Bullets or other metal fragments?				
Tattoos or tattooed eyeliner (permanent makeup)				
Any Allergies?				
Asthma?				
Type I or II Diabetes?				
History of Seizures or Convulsions?				
Ischemic Cardiac disease (heart problems such as blocked arteries, history of heart attack?)				
Kidney or Renal Disease?				
Are you on dialysis: Hemo-dialysis or Peritoneal				
Date of next appointment:				
Liver disease?				
Peripheral vascular disease? (problems with blood vessel circulation in arms and/or legs)				
Sickle Cell Disease or Hemolytic Anemia?				
A history of Strokes? TIAs?				
Do you have Nephrogenic Systemic Fibrosis (NSF)?				
Are you Claustrophobic?				

<p>Have you ever had a surgical procedure or operation? _____</p> <p style="text-align: center;">Yes No</p> <p>List all surgeries _____</p> <p>Year _____</p>	<p>MRI staff to fill out if Client has: renal failure and/or are on Renal Dialysis.</p> <p>Creatinine level _____ GFR _____</p> <p>Date collected: _____</p> <p>Checked with Radiologist: Dr. _____ N/A</p> <p>Rad. Consult with Dr. _____ N/A</p> <p>Post Exam Dialysis requested by Physician? Yes No</p> <p>Follow up instructions given to patient if applicable? Yes No</p>
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Have you ever had an injection of MRI contrast (dye) before? Yes – any problems? _____ No

Have you **ever** had an injury from a metal object in your eye (metal slivers, metal shavings, other metal objects?)
 Yes, explain _____ No

If yes, did you seek medical attention? Yes No Were x-rays of your eyes done? Yes, where? _____ No

MRI staff to fill out: Orbit report attached Yes N/A MRI since injury @ _____ year _____ Orbits cleared by _____

Are you pregnant or do you suspect that you are pregnant? Yes No LMP _____

Are you breast feeding? Yes No

For Clients with advanced Renal/Kidney Disease or who are on renal dialysis:

NSF (Nephrogenic Systemic Fibrosis is a very rare condition of which the cause is unknown, however it is known to occur in some clients with advanced renal disease and who are on renal dialysis. This disease can cause thickening and hardening of the skin, red patches, itching or swelling of the skin, joint stiffness and very rarely may affect the lung and other organs. Some studies have suggested that getting an injection of MRI dye (gadolinium) has been linked with a very small number of clients developing NSF. Even in clients with severe or end stage renal disease, the change of developing NSF is very rare. Other imaging methods have been explored and MRI will help in the diagnosis and treatment of your condition. If, after receiving the MRI dye, you should develop any of these signs or symptoms, please follow up with your doctor right away.

As you are having Magnetic Resonance Imaging (MRI), it is important that you be informed about the procedure.

You may need to have an injection of “dye” or contrast. The contrast will be given by an injection into a vein in your hand, arm or leg; this dye makes certain diseases and important body structures more visible on MRI images.

Most people have no ill effects from the contrast. Sometimes mild reactions do occur but pass without treatment or respond quickly to medication. The risks or reactions associated with the contrast injection may include but are not limited to a ‘sweet’ taste in your mouth, headache and discomfort at the site of the injection, nausea and itchiness. Very rarely some people have pain in other parts of their body, dizziness, vomiting, parasthesia (your skin may feel like it is burning itching or tingling) or an allergic reaction (hives, watery eyes). Very rarely a more severe allergic reaction to the dye could occur, causing shock. You must receive treatment to correct this reaction. There is a very slight chance of coma and death. If you feel any discomfort or experience any of these symptoms, please tell the technologist doing your test. It is the belief of the doctors caring for you that the MRI will help in the diagnosis and treatment of your condition.

*Should you have any of these symptoms after your test, please contact your doctor or call _____

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

Patient / Legal Guardian Signature _____ Date _____

Witness _____ Title of Witness _____

(Health Care Provider)

I, _____ (name of client/legal representative) consent to and confirm that the nature and anticipated effects of injecting contrast dye for the purpose of a Diagnostic Imaging exam, including the specific risks, have been explained to me by _____ and that available alternatives have been discussed with me by the physician who is requesting this examination, and I am satisfied with, and understand the information provided to me. I have had the opportunity to ask questions and they have been answered to my satisfaction.

Signature of: Client / Legal Representative

Printed name of client/legal Representative

Date (yyyy/mon/dd)

Time

Witness Signature

Witness Printed Name

Physician/Health care provider Certification:

I hereby certify that I have explained the above procedure to _____, who, in my opinion, understands the nature and risks of the procedure.

Signature of Physician/ Health care provider

Printed name of Physician/ Health care Provider

Translators:

I certify that I have read or translated all of the above information to the person who has signed this, and I am satisfied that I have correctly read or translated the information.

Signature

Name (Please print)

Date (yyyy/mon/dd)

DI Use: Contrast Injected by: _____ @ _____ hrs. **Amount** _____ **Lot #** _____
Contrast Type: Gadolinium Other _____ **Exp. Date** _____