Monterey Spine & Joint

MR #: _____

MRI AND IV CONTRAST SCREENING QUESTIONNAIRE

Patient Name: _____ Date: _____

Sex: **M** **F** Height: _____ Weight: _____ DOB: _____ Age: _____

Referring Physician: _____

Are you pregnant: **YES** **NO** **N/A** Last Menstrual Period: _____ Post-Menopausal: **Yes** **No**

Reason you are here today for an exam: _____

Explain your medical problem in detail. (What happened? Where did it happen? How long have you had this problem?)

_____

_____

YES **NO** Do you have pain? Where? _____

YES **NO** Have you had any surgeries in the area(s) that are being imaged today? Where: _____

YES **NO** Have you taken any medication/sedation/alcohol today to help you relax for this procedure? If yes, please list: _____ time taken: _____

YES **NO** Do you have a personal history of cancer or tumor? If yes, please list: _____

_____

YES **NO** Have you had a previous exam related to this problem? If yes, explain: _____

_____

IMPORTANT: Do you have any of the following? If so, circle **Yes.**

Heart Surgery/Heart Valve/Prosthesis	**Yes**	**No**	Brain Surgery/Brain Aneurysm Clips	**Yes**	**No**
Implanted Cardiac Pacemaker	**Yes**	**No**	Orthopedic Pins/Rods/Screws and/or Plates	**Yes**	**No**
Implanted Defibrillator (ICD)	**Yes**	**No**	Artificial or Prosthetic limb	**Yes**	**No**
Shunts/Stents/Intravascular Coil/Filters	**Yes**	**No**	Metal/Mesh Implants/Wire Sutures/ Staples	**Yes**	**No**
Eye Surgery/Implants/Spring or Wire	**Yes**	**No**	Any Electrical/Magnetic/Mechanical implants	**Yes**	**No**
Injury to eye involving metal or metal shavings	**Yes**	**No**	Gunshot Wounds or Shrapnel	**Yes**	**No**
Neurostimulator/Biostimulator	**Yes**	**No**	BB's or Metallic Fragments	**Yes**	**No**
Spinal Cord Stimulator	**Yes**	**No**	Radiation Therapy or Chemo Therapy	**Yes**	**No**
Vascular Access Ports and/or Catheter	**Yes**	**No**	Radiation Seeds or Implants	**Yes**	**No**
Pacing Wires/Swan-Ganz or any other catheter	**Yes**	**No**	IUD/Diaphragm/Pessary	**Yes**	**No**
Insulin or Medication (Drug) infusion Pump	**Yes**	**No**	Penile Prosthesis	**Yes**	**No**
Bone growth/Bone Fusion Stimulator	**Yes**	**No**	Hearing Aids/Ear Surgery/Cochlear Implants	**Yes**	**No**
Tissue Expander (e.g. breast)	**Yes**	**No**	Any Other Ear Implant	**Yes**	**No**
Internal Electrodes or Wires	**Yes**	**No**	Tattoos/Permanent Make-up	**Yes**	**No**
Medication Patch (Nicotine, Nitroglycerine)	**Yes**	**No**	Body Piercings, Hair Extensions, Wigs	**Yes**	**No**
Blood disorder/ Sickle Cell Anemia	**Yes**	**No**	Dentures/Partials/Dental Implants	**Yes**	**No**
Seizures/Headaches/Dizziness	**Yes**	**No**	Asthma/Allergic Respiratory Disease/COPD	**Yes**	**No**
Claustrophobia	**Yes**	**No**	Any Other Implant	**Yes**	**No**

If you answered **Yes** to any of the above, please explain in detail below:

_____

_____

_____

_____

Monterey Spine & Joint

MR #: _____

MRI CONTRAST CONSENT

Due to your medical history, or as requested by your physician, and injection of MRI Gadolinium Contrast may be necessary to aid the Radiologist in evaluating your MRI scan. The Food and Drug Administration has approved this agent. Although gadolinium contrast agents have been used safely in millions of patients, minor reactions (principally headache or nausea), and serious or life-threatening reactions may occur. **Check YES or NO for each item if you are to receive contrast for your exam**.

Do you have any allergies, or allergies to medication?	**Yes**	**No**
Blood disorder or Sickle Cell Anemia	**Yes**	**No**
Kidney Surgery/Transplant/Single Kidney/Kidney Disease or Kidney Injury?	**Yes**	**No**
Hypertension requiring medicine?	**Yes**	**No**
Liver Disorder/Dialysis	**Yes**	**No**
Have you ever had a reaction to MRI contrast in the past?	**Yes**	**No**
Are you currently breastfeeding?	**Yes**	**No**
Have you ever had an injection of contrast before?	**Yes**	**No**

If you answered **Yes** to any of the above, please explain in detail below:

_____

_____

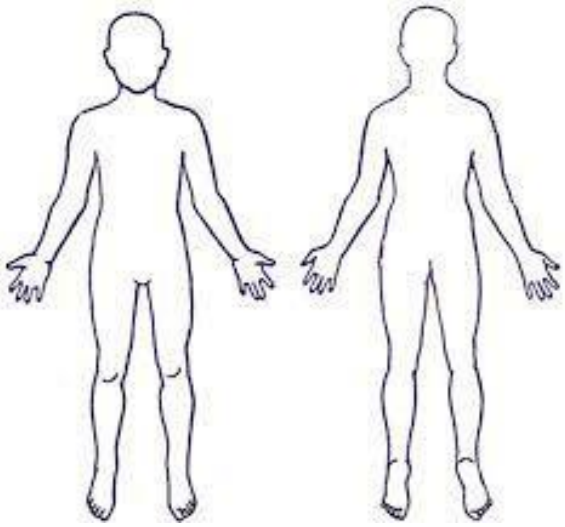
The technologist has explained the procedure to me, I have received and read the medication guide for the gadolinium-based contrast agent that may be used as part of my MRI examination and I have had my questions answered.

□ I **CONSENT** to have the MRI procedure with injection of contrast if deemed necessary. Check box if you agree to contrast.

□ I **DECLINE** having a Gadolinium contrast injection at this time. Check box if you disagree to contrast.

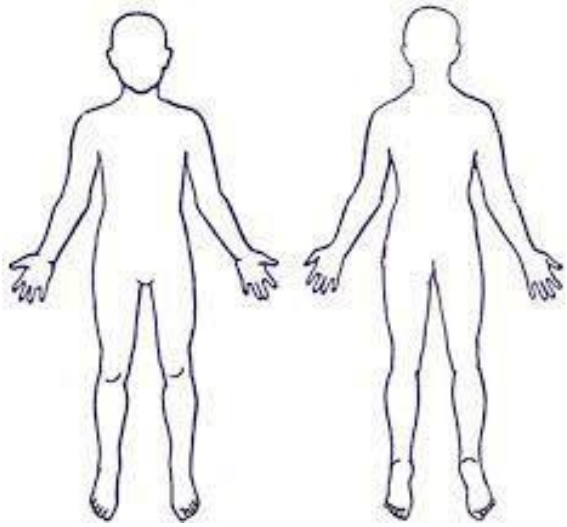
Patient/Guardian Signature: _____ **Technologist Signature**: _____

Draw where your pain or symptoms are located:



FRONT BACK

Draw location of any metal in your body on the figure below:



FRONT BACK

Acknowledgement: I attest that the above information is correct to the best of my knowledge. I have 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. I have also informed the technologist that at this time I am **pregnant OR NOT pregnant.**

Patient Name Printed: _____ Patient Signature: _____

Date: _____Time:_____AM or PM

Witness Name Printed: _____Witness Signature: _____

Date:_____Time:_____AM or PM