NORTHERN NEVADA IMAGING
MRI PRESCREENING/CONSENT FORM

Date: _____
Name (first middle last) _____
Female [ ] Male [ ] Age _____ Date of Birth _____
Height _____ Weight _____
Why are you having this examination (medical problem)?
_____

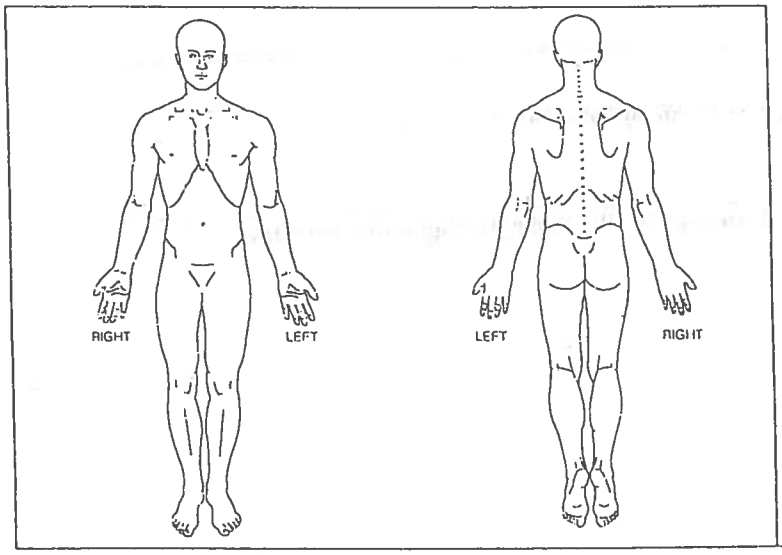
YES NO
Have you ever had an MRI examination before and had a problem?
____ ____
If yes, please describe _____
Have you ever had a surgical operation or procedure of any kind?
____ ____
If yes, list all prior surgeries and approximate dates:
_____
_____
Have you ever been injured by a metal object or foreign body (e.g., bullet, BB, shrapnel)?
____ ____
If yes, please describe _____
_____
_____
Do you have a history of claustrophobia?
____ ____
(NURSING, IF YES, PLEASE OBTAIN AN ORDER FOR SEDATION MEDICATION FROM ATTENDING PHYSICIAN.)

Have you ever had an injury from a metal object in your eye (metal slivers, metal shavings, other metal object)?
____ ____
If yes. did you seek medical attention? _____
If yes. describe what was found _____
Do you have a history of kidney disease, asthma, or other allergic respiratory disease?
____ ____
Do you have any drug allergies?
____ ____
If yes. please list drugs _____
_____
Have you ever received a contrast agent or X-ray dye used for MRI, CT, or other X-ray or study?
____ ____
Have you ever had an X-ray dye or magnetic resonance imaging (MRI) contrast agent allergic reaction?
____ ____
If yes, please describe _____
_____
Are you pregnant or suspect you may be pregnant?
____ ____
Are you breast feeding?
____ ____
Date of last menstrual period_____ Post-menopausal? _____

MR Hazard Checklist

Please mark on the drawing indicating the location of any metal inside your body or site of surgical operation.

The following items may be harmful to you during your MR scan or may interfere with the MR examination. You must provide a "yes" or "no" for every item. Please indicate if you have or have had any of the following:



YES NO
____ ____ Any type of electronic, mechanical, or magnetic implant
Type _____
____ ____ Cardiac pacemaker
____ ____ Aneurysm clip
____ ____ Implantable cardiac defibrillator
____ ____ Neurostimulator
____ ____ Biostimulator
Type _____
____ ____ Any type of internal electrodes or wires
____ ____ Cochlear implant
____ ____ Hearing aid
____ ____ Implanted drug pump (e.g., insulin, baclofen, chemotherapy, pain medicine)
____ ____ Halo vest
____ ____ Spinal fixation device
____ ____ Spinal fusion procedure
____ ____ Any type of coil, filter, or stent
Type _____
____ ____ Any type of metal object (e.g., shrapnel, bullet, BB)
____ ____ Artificial heart valve
____ ____ Any type of ear implant
____ ____ Penile implant
____ ____ Artificial eye
____ ____ Eyelid spring

Patient Identification

Northern Nevada
MEDICAL CENTER
2375 E. PRATER WAY
SPARKS, NEVADA 89434

MRI PRESCREENING/CONSENT FORM

Standard Register
CO0010
FORM #10-53369 (8/10)

Safe MR Practices

____ ____ Any type of implant held in place by a magnet
Type _____
____ ____ Any type of surgical clip or staple
____ ____ Any IV access port (e.g.. Broviac, Port-a-Cath, Hickman, PICC line)
____ ____ Medication patch (e.g., nitroglycerine, nicotine)
____ ____ Shunt
____ ____ Artificial limb or joint
What and where _____
____ ____ Tissue expander (e.g.. breast)
____ ____ Removable dentures, false teeth, or partial plate
____ ____ Diaphragm, IUD, pessary
Type _____

____ ____ Surgical mesh
Location _____
____ ____ Body piercing
Location _____
____ ____ Wig. hair implants
____ ____ Tattoos or tattooed eyeliner
____ ____ Radiation seeds (e.g., cancer treatment)
____ ____ Any implanted items (e.g.. pins. rods, screws, nails, plates, wires)
____ ____ Any hair accessories (e.g., bobby pins, barrettes. clips)
____ ____ Jewelry
____ ____ Any other type of implanted item
Type _____

Renal disease (including solitary kidney, renal transplant, renal tumor)	Yes	No	Creatinine Clearance
Age >60	Yes	No	
History of Hypertension	Yes	No	Dept. use:
History of Diabetes	Yes	No	
History of severe hepatic disease/liver transplant/pending liver transplant	Yes	No	

Certain implants, devices, or objects may be hazardous to you in the MR environment or MR system room. Do not enter the MR environment or MR system if you have any question or concern regarding an implant, device, or object Your physician has requested a MR examination, which may involves injection of contrast material into the body. It is important that you be aware of possible complications involved. Patients with moderate to end stage kidney/renal function would be at risk of Nephrogenic Systemic Fibrosis (NSF). This is vary rare. Please consult the MRI Technologist or Radiologist if you have any question or concern **BEFORE** you enter the MRI area.

I have read and understand the above questions/consent and agree to have this procedure preformed. My signature on this document indicates that I had the opportunity to have the radiologist, or other administering physician, explain to my satisfaction the procedure to be undertaken, alternative treatments or procedures, if any, and the nature and extent of the medical risks involved.
I acknowledge that no guarantee or assurance has been made.

_____
(In Patients) Nursing Signature who preformed screening with Patient.

_____ **Contrast given:** ☐ No ☐ Yes **Type and Amount** _____
Exam

_____
Patient/Representative Signature and Date

_____
Witness/MRI Technologist Signature and Date

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