Patient Information

Baptist Health

MRI PATIENT HISTORY AND CONTRAST CONSENT FORM

History/Symptoms:_____

_____

_____

Injury: ❑ Yes ❑ No Type:_____ Date:_____

Surgical History:

Head/Brain:_____

Neck/Chest:_____

Spine:_____

Bone/Joint:_____

Abdomen/Pelvis:_____

Have you ever been diagnosed with cancer? ❑ Yes ❑ No Type:_____ Date:_____

Radiation Therapy: ❑ Yes ❑ No Anatomy:_____

Chemo Treatment ❑ Yes ❑ No

Have you been diagnosed with:

❑ Asthma	❑ Alzheimer's	❑ Atherosclerosis	❑ Coronary Artery Disease
❑ COPD	❑ CVA	❑ Congestive Heart Failure	❑ Chronic Kidney Disease
❑ Diabetes	❑ Dialysis Treatments	❑ DVT ❑ HTN	❑ Migraine Headaches
❑ Osteoarthritis	❑ PVD	❑ Osteoporosis	❑ Rheumatoid Arthritis

_____ _____

Signature of Patient/Responsible Party(relationship) Date and Time

_____ _____

Witness/Technologist Date and Time

* For unresponsive patients, a review of the patient's medical history and any medical images will be assessed by a radiologist prior to entering the MRI scan room: Radiologist verifying images & medical history:_____

❑ Exam is ordered without IV contrast

❑ Exam is ordered with IV contrast

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Are you currently taking any home medications (prescription and/or non-prescription) ❑ **Yes** ❑ **No**
If YES, please complete home medication record.

Creatinine results are required for patients 50 years of age and older, diabetic history, renal disease, multiple myeloma, or family history of renal failure prior to any contrast injection.

MR Exam:_____

Creatinine:_____ Result Date:_____ GFR:_____

Have you ever had an allergic reaction to IV contrast: ❑ Yes ❑ No Date of Reaction:_____

Type of reaction:_____

I UNDERSTAND THAT THIS CONTRAST AGENT (LIKE MANY NEW DRUGS) MAY CAUSE AN ALLERGIC REACTION.

I understand that my physician may have requested the use of an intravenous contrast media that will assist the radiologist in better distinguishing certain anatomy or abnormalties that would otherwise be difficult or impossible to see.

I understand that the procedure to be performed on me involves the use of a high strength magnetic field, and possibly insertion needles and gadolinium containing solution, which may enhance the diagnostic accuracy of the procedure.

I understand that I may be receiving an intravenous contrast media and/or oral contrast media to enhance the visibility of certain tissues. Possible side effects may include, but are not limited to, pain or swelling at the site of injection, nausea, vomiting, and a warm, flushed sensation. Also potential allergic reactions including, but not limited to, hives, wheezing, difficulty breathing, and in rare instances, anaphylactic shock (with severe allergic reactions).

The purpose, benefits, and complications of the contrast procedure will be explained prior to any injection that may take place.
I hereby consent to any measure neccesary to correct complications, which may occur. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantee has been made to me concerning the results of the examination.

I confirm that the information I have provided is complete and accurate to the best of my knowledge.

I UNDERSTAND THE RISKS, BENEFITS, AND ALTERNATIVES INVOLVED IN THE PROCEDURE. I HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION.

_____ _____
Signature of Patient or Responsible Party (relationship) Date and Time

_____ _____
Witness/Technologist Date and Time

IV Contrast Media/Amount:_____

IV/Injection Site:_____

Injection Time:_____

Patient Tolerated Procedure Well: ❑ Yes ❑ No

Reaction: Type:_____ Time:_____

Treatment:_____

IV/Injection Site after injection and after Needle Removal:

❑ No Redness ❑ No Swelling ❑ Catheter Intact

Radiologist:_____

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Form # CO 15061 Revised 08/10/2009