SJRA

SOUTH JERSEY RADIOLOGY ASSOCIATES, P.A.

MRI Patient Information

Exam date _____

Patient name _____ DOB _____

○ Female ○ Male Height _____ Weight _____

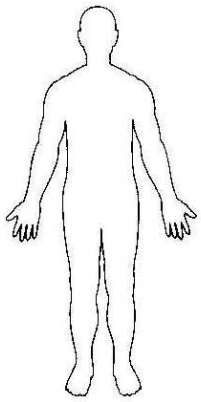
If patient is a minor, parent's name _____

1. Is there any chance of pregnancy? ○ **Y** ○ **N** Date of last menstrual period _____
2. Are you currently breast feeding? ○ **Y** ○ **N**
3. Have you ever had an eye injury requiring medical attention? ○ **Y** ○ **N** If yes, please describe:

   _____
4. The following items can interfere with MR imaging; please check if you have any of these:

- ☐ Cardiac Pacemaker
- ☐ Brain clips
- ☐ Aortic clips
- ☐ Neurostimulators (TENS-UNIT)
- ☐ Heart Valve
- ☐ Insulin pump
- ☐ Electrodes
- ☐ Hearing Aid
- ☐ IUD
- ☐ Shunt
- ☐ Stent
- ☐ Breast expanders
- ☐ Penile Implant
- ☐ Medication Patch
- ☐ Harrington rod
- ☐ Bone or Joint pins
- ☐ Artificial Joint or Prosthesis
- ☐ Metal mesh
- ☐ Wire sutures
- ☐ Shrapnel
- ☐ Dentures or Removable Dental Work
- ☐ Metal fragments in head, eye, body
- ☐ Cochlear / Stapes implants
- ☐ Fractured bones (pins, plates, metal rods, screws)
- ☐ OTHER; Please list: _____

5. Please mark on the drawing the location of any known or suspected metals inside your body:



6. Please review the list below and remove any of these articles. Lockers will be provided before entering the MRI suite (Glasses, dental work and shoes can remain with you until you enter the exam room):

Hair pins, barrettes	*Back brace*	*Jewelry (other than 14K rings)*
Metal bra hooks	*Watch / Keys*	*Bra & Girdle underwire support*
Magnetic strip cards (Credit & Bank cards)	*Sanitary belt*	*Safety pins*
	Wallet / Money Clip / Coins	*Hearing aides*

Patient name: _____

7. What symptoms are you having that led to this test?

_____

_____

8. List previous surgeries: Dates

_____ _____

_____ _____

_____ _____

_____ _____

9. Any other medical problems?

_____

_____

10. Any previous studies?

	Where	When
MRI	_____	_____
CT SCAN	_____	_____
MYELOGRAM	_____	_____
ANGIOGRAM	_____	_____
X-RAYS	_____	_____

11. Are you currently on Dialysis? ○ **Y** ○ **N**

12. Are you a diabetic on insulin or prescribed medication? ○ **Y** ○ **N**

13. Have you had an organ transplant? ○ **Y** ○ **N**

14. Have you had kidney disease? ○ **Y** ○ **N**

15. Have you ever had kidney or bladder surgery? ○ **Y** ○ **N**

16. Do you have lupus, rheumatoid arthritis or college vascular disease? ○ **Y** ○ **N**

Your exam may require the injection of MRI Contrast agent (Gadolinium). There is a rare complication of Gadolinium administration, Nephrogenic Systemic Fibrosis (NSF). This may require laboratory evaluation of selected patients' renal function. There are additional infrequent reactions to Gadolinium, including hives, rash, or a rare life threatening reaction may occur. If you have ever had a reaction to Gadolinium (MRI Contrast) previously, please inform the MRI Technologist.

A technologist will be with you shortly to explain the procedure, escort you to the changing room and answer any questions you may have. Because this is a time-consuming procedure, please use the restroom before you are called for your scan. Please sign below to indicate you have read and understand this form.

I have read and understand and all my questions have been answered.

Patient Signature _____ Date: _____

MRI Technologist _____ _____ Date: _____