ORTHOPAEDIC SPECIALTY GROUP, P.C.
Exceptional People. Exceptional Care.

Magnetic Resonance Imaging (MRI) History Form and Consent

Patient Name: _____ Cell# _____
Area to be scanned: _____ Email:_____
Referring Physician: _____ Height: _____
Date of Birth: _____ Weight: _____

****Eligibility Criteria. Please circle Yes or No to the questions below****

YES NO 1. Are you **pregnant** or **suspect pregnancy**?
YES NO 2. Do you have an **IUD** (intrauterine device), **Diaphragm/Pessary Ring**? Type:_____
YES NO 3. Do you have a **pacemaker, defibrillator** or **wires** still in place?
YES NO 4. Have you had a **coronary bypass** or **artificial heart valves**?
YES NO 5. Do you have a **cardiac stent**?
YES NO 6. Have you had any **vascular (blood vessel) surgery/ catheters, stents, clips, coils or filters**?
YES NO 7. Have you had **brain surgery**?
YES NO 8. Have you had a **brain aneurysm repair**?
YES NO 9. Do you have **metallic implants**? **Joint replacements, plates, screws, pins, anchors, wires,**
YES NO 10. Do you have any **body piercings**?
YES NO 11. Have you gotten a **recent tattoo** or **permanent makeup (within 8-10wks)**?
YES NO 12. Have you ever had a **shrapnel (metal)** or **gunshot** injury?
YES NO 13. Have you ever had any **Metal Injury** to **eyes, head, or skin** (metal worker, welder)?
YES NO 14. Have you had any **eye surgery**? Type:_____Date:_____
YES NO 15. Do you have a **hearing aid?**
YES NO 16. Have you ever had **Middle Ear Surgery** (cochlear or stapes implant)?
YES NO 17. Do you have **braces, dentures, or retainers?** Permanent _____Removable_____
YES NO 18. Do you wear a **wig** or **hair extensions with micro beads/clips?**
YES NO 19. Do you have a **seizure disorder (epilepsy)**? Date of last seizure: _____
YES NO 20. Do you have a **neurostimulator** or any **electronic implants**?
YES NO 21. Do you have any type of **Prosthesis (limbs, eye, penile)** or **tissue expander**?
YES NO 22. Do you have an **insulin pump**?
YES NO 23. Do you have **medication patches on**?
YES NO 24. Have you ever had **cancer**? Type:_____Treatment: _____
YES NO 25. Do you have a history of **Claustrophobia**? (fear of closed in or tight places)
YES NO 26. Have you had any **surgery in your lifetime**? If Yes, **list all surgeries** below:

_____

_____

_____

I have understood and accurately answered all the above questions.

Patient Signature: _____ Date: _____
If the patient is a minor, disabled or unable to give consent; Signature of a guardian or the other legally responsible person:
Signature: _____ Date: _____ Relationship: _____

****For Exams ordered with an IV Injection, Please continue on the back of this form****

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Magnetic Resonance Imaging (MRI) with Gadolinium

Your magnetic resonance imaging examination may include images made after an injection of gadopentate dimeglumine (subsequently referred to as gadolinium). The gadolinium injection may allow the radiologist to identify additional details about your condition that might not be apparent without the use of gadolinium. In some areas, the examination is much less useful if gadolinium is not used.

Gadolinium will be injected into a vein at which time there may be slight burning at the injection site. Gadolinium is filtered out of the bloodstream by your kidneys and eliminated from your body in your urine. Gadolinium will be eliminated from your body approximately 24 hours after the injections.

We do not currently use gadolinium in patients who are pregnant, nursing or in patients with certain kinds of anemia or sickle cell disease.

Please complete the checklist below regarding these situations.

Nursing: ____YES_____NO

Pregnant: ____YES_____NO

Asthma or Allergies:_____YES_____NO

Kidney Problems:_____YES ____NO

Hemoglobin Disease:_____YES_____NO

Anemia:_____YES_____NO

Sickle Cell Anemia (Or Trait)____YES____NO

Red Blood Cell Disease:_____YES____NO

Have you had any recent administration of a gadolinium-based contrast agent?

_____YES _____NO **IF YES, how long ago?** _____

Have you ever experienced an adverse reaction to gadolinium?_____YES_____NO

If YES to any of the above questions, please explain: _____

_____

I understand I have the right to refuse the use of gadolinium and still undergo the Magnetic Resonance Imaging (MRI) scan, although it may limit the usefulness of the scan. I have read and understood the above explanation and choices, and consent to the examination.

Patient Signature:_____ Date: _____

If the patient is a minor, disabled, or otherwise unable to give consent, signature of a guardian, substitute consenter, or other legally responsible person is requested.

Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

Signature of Witness:_____ Date: _____