Big Sky Diagnostic Imaging of Billings

MRI Procedure Screening and Consent

PATIENT INFORMATION

NAME:	DOB:	WEIGHT:
BODY PART TO BE EXAMINED:		PHYSICIAN:

REASON FOR MRI/MRA (SYMPTOMS AND/OR CONDITION):

WARNING

The MR system has a very strong magnetic field that may be hazardous to individuals entering the MR environment or MR system room if they have certain metallic, electronic, magnetic, or mechanical implants, devices, or objects. The magnetic field is ALWAYS ON. You must remove: hearing aids, beepers, cell phone, keys, eyeglasses, hair pins, barrettes, jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, coins, pocket knives, any loose metallic object, or any item that may be metallic BEFORE entering the MR system room.

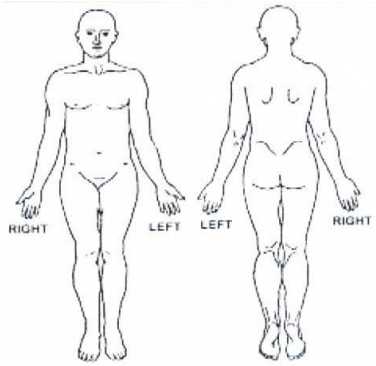
SCREENING

1.	Have you ever had a prior surgery or operation of any kind?	❑Yes	❑No
	If "Yes" please give a brief description and date of surgery:_____		
2.	Have you ever had a prior MRI?	❑Yes	❑No
	If "Yes": When?_____ Where?_____ What body part?_____		
3.	Have you ever had an injury to your eyes or body involving a metallic object or fragment?	❑Yes	❑No
4.	Do you have any conditions and/or disease(s) of your heart?	❑Yes	❑No
5.	Do you have diabetes or any disease(s) of your kidneys or blood?	❑Yes	❑No
6.	Do you experience anxiety in closed environments (claustrophobia)?	❑Yes	❑No
7.	Have you ever experienced any adverse events or problems related to a previous MRI?	❑Yes	❑No
8.	Have you ever had an allergic reaction to contrast ("dye") during a radiology procedure?	❑Yes	❑No
9.	Do you have asthma, respiratory disease, or drug allergies?	❑Yes	❑No
10.	Are you pregnant or experiencing a late menstrual cycle?	❑Yes	❑No
11.	Are you currently breast feeding?	❑Yes	❑No

INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

Aneurysm clip(s)	❑Yes	❑No
IUD or internal birth control device	❑Yes	❑No
Cardiac pacemaker or defibrillator (ICD)	❑Yes	❑No
Any magnetically activated or electronic implant or device	❑Yes	❑No
Any type of shunt, stent, or infusion pump	❑Yes	❑No
Any type of prosthetic device or artificial limb	❑Yes	❑No
Inner ear or cochlear implant	❑Yes	❑No
Any neuro, spinal cord, or bone growth stimulator	❑Yes	❑No
Medication patch on skin	❑Yes	❑No
Dentures or removable dental work	❑Yes	❑No
Any type of internal or external metallic object	❑Yes	❑No
Hearing aids	❑Yes	❑No

Mark the location of any implant or metal on the figures below.



CONSENT

I attest that all the information provided is correct to the best of my knowledge. I have read and understand the entire content of this form and have had the opportunity to address any questions or concerns I have regarding the information pertaining to this form. My signature also indicates that I consent to Big Sky Diagnostic Imaging performing any intravenous injection of contrast material that my physician or the Radiologist deems necessary. I understand there is a potential risk of mild to severe adverse side effects when receiving this contrast, including a severe anaphylactic allergic reaction requiring medical intervention, the administration of medicines, and possible hospitalization. I understand small amounts of contrast may be retained in the body and potentially involve rare conditions such as fibrosis of the skin, muscles, or internal organs. If receiving contrast, I have been provided with the opportunity to review a gadolinium medication guide. I understand I have the right to refuse the use of this contrast material.

Signature of person completing form:	Date:
Technologist's notes:	Technologist: