

Reference (WDpsiMed#): _____

MRI HISTORY AND SCREENING:

Today's Date ___/___/___ Patient's Name: _____

Last 4 Digits of SSN _____ Sex: _____ Height _____ *Weight: _____
* (< 400 pounds)

Date of Birth: ___/___/___ Age: _____

Referring Physician _____ Primary Care Provider _____

Please list all known allergies: _____

Reason for today's MRI: _____ What are your symptoms: _____

Have you had a previous MRI? YES NO

PLEASE ANSWER CAREFULLY, DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

- Yes No Pacemaker/pacemaker wires
- Yes No Heart Valve/ Heart surgery/ stents/ shunts
- Yes No Implanted cardiac defibrillator
- Yes No Brain aneurysm clip/ Other brain surgery
- Yes No Ear surgery/Cochlear Implant/Inner ear prosthesis
- Yes No Vascular access port, central venous catheter
- Yes No Metal slivers in eye; history of welding or metal grinding
- Yes No Shrapnel/Bullet fragments/BBs/wires/Other metal foreign body
- Yes No Neurostimulator/TENS/Muscular stimulator (pelvic floor, etc.)
- Yes No Insulin pump/Pain pump
- Yes No Diaphragm/IUD
- Yes No Penile implant/Pessary/Metal mesh
- Yes No IVC filter/Joint replacement/metal plates, screws, clips, orthopedic implants
- Yes No Eye surgery/Ocular implants
- Yes No Do you have a history of cancer? If so, what type? _____
- Yes No Hearing aids/Removable dentures
- Yes No Are you breastfeeding or pregnant? Date of last menstrual period: _____
- Yes No Previous spine surgery?
- Yes No Tattoos/Piercing with metal jewelry/Permanent makeup
- Yes No History of: seizures, asthma, Diabetes, chest pain, liver problems, hepatitis, arrhythmia, sickle cell disease.

Please describe any type of surgery that you have had and the approximate date of the procedure:

_____ Date: ___/___/___

_____ Date: ___/___/___

_____ Date: ___/___/___

Will a specialist need a copy of the study you are having today? If yes, please fill in:

Name of specialist: _____

Specialist Address: _____

Specialist phone number: _____

I have answered the above questions to the best of my knowledge and understand the information presented to me regarding MRI. I am not pregnant at this time. I consent to MR examination.

Patient's/ Guardian's Signature and Printed Name: _____

Technologist Initials _____

DISCLOSURE AND CONSENT

TO THE PATIENT: You have the right, as a patient, to be informed about the recommended procedure to be performed so you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

1. I voluntarily request the physicians, technologists, and other health care providers at Bexar Imaging Center to perform radiological tests on me as ordered by my physician to further evaluate my medical condition.
2. I understand that nonionic IV contrast (such as that used for CT scans, IVPs, cardiac catheterizations, and other radiologic exams) will be administered to me if indicated for this procedure.
3. I understand that nonionic IV contrast is associated with the following risks: severe allergic reaction which can lead to death, less severe but still complicated allergic reactions, cardiovascular reactions, hives, shortness of breath, skin damage at the site of the IV, and permanent kidney damage.

Patient's signature or other legally responsible person

Date: _____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: _____ Relationship: _____

Address: _____ City/State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Counseling physician: David Rotter, M.D. _____

Counseling technologist: Doug Lanford Carlos Herrera Michelle Earl