

Patient Name _____ **Date of Birth** _____ **Weight** _____

Please answer the following (All must be checked YES or NO)

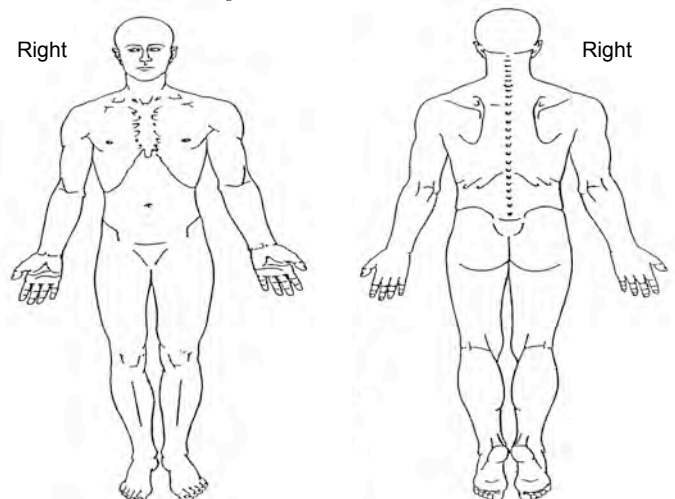
<p>YES</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>NO</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Are you receiving this MRI as a result of having sustained an injury?</p> <p>Are you pregnant?</p> <p>Have you had an MRI, MRA, or CT before? If YES, Where? _____ When? _____ What body part? _____</p> <p>Have you had any previous surgeries? If YES, please indicate the date and type of surgery: Date _____ Type of surgery _____ Date _____ Type of surgery _____</p> <p>Have you ever been diagnosed with cancer? If YES, please state the name of your cancer and the location in your body _____</p> <p>Have you had chemotherapy? If YES, when was your last treatment? _____</p> <p>Have you had radiation therapy? If YES, when was your last treatment? _____</p>
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Please describe the symptoms you are having which pertain to you having *this* exam and how long you have been having these symptoms:

Mark your symptoms with an "X"

- _____ Headaches
- _____ Vision Loss/Changes
- _____ Dizziness
- _____ Numbness in Arms or Legs
- _____ Hearing Loss Right/Left (circle)
- _____ Ringing in Ears
- _____ Change in Bowel Functions
- _____ Change in Bladder Functions
- _____ Lump or Mass:
Location: _____
- _____ Swelling:
Location: _____

Mark areas of pain with an "X"



CONTINUED ON THE OTHER SIDE. PLEASE TURN OVER.

The federal government has required us to identify alternate providers of this service. This list is not intended as a recommendation.

ProScan Imaging Midtown
5400 Kennedy Avenue
Cincinnati, OH 45213
Phone (513) 618-1063

ProScan Imaging
6 Paul Brown Stadium
Cincinnati, OH 45202
Phone (513) 455-4999

West Image
3285 Westbourne Drive
Cincinnati, OH 45248
Phone (513) 451-7500

Varsity Village Imaging Center
2650 Varsity Village Drive
Cincinnati, OH 45219
Phone (513) 556-4674

Glenway Imaging
6350 Glenway Avenue, Ste 102
Cincinnati, OH 45211
Phone (513) 661-2046

IMPORTANT

**CERTAIN IMPLANTS, DEVICES, OR OBJECTS MAY INTERFERE WITH THE MR PROCEDURE!
THE MR SYSTEM MAGNET IS ALWAYS ON!**

Do you have any of the following? (All must be checked YES or NO)

<u>YES</u>	<u>NO</u>	
_____	_____	COCHLEAR /STAPES (INNER EAR) IMPLANT
_____	_____	CARDIAC PACEMAKER
_____	_____	CARDIOVERTER or DEFIBRILLATOR
_____	_____	ANEURYSM (BRAIN) or AORTIC (HEART) CLIP
_____	_____	ARTIFICIAL HEART VALVE
_____	_____	INTRAUTERINE DEVICE
_____	_____	STENT (CARDIAC or OTHER)
_____	_____	VENA CAVA FILTER
_____	_____	SHRAPNEL
_____	_____	METAL FRAGMENTS IN HEAD, EYE or SKIN
_____	_____	IMPLANTED SPINAL CORD STIMULATOR/NEUROSTIMULATOR (TENS UNIT)
_____	_____	IMPLANTED INSULIN PUMP
_____	_____	Electrodes
_____	_____	Eye Implant
_____	_____	Joint Replacement
_____	_____	Prosthesis
_____	_____	Wire Sutures
_____	_____	Hearing Aid
_____	_____	Shunt (Spinal or Ventricular)
_____	_____	Fractured Bones - Treated with Metal (Rods, Plates, Pins, Screws, Nails, Clips)
_____	_____	Metal Mesh Implants
_____	_____	Permanent Hair Implants/Clips
_____	_____	Dentures
_____	_____	Nicotine or Medication Patch
_____	_____	Are You Pregnant?
_____	_____	Other Metal Implants (Please List) _____

If you check "YES" to anything in this box, you must contact our MRI Center **prior** to your scan.
(513) 721-7226

Patient's Signature _____

Date _____

Parent/Guardian Signature _____

Tech's Initials _____

FOR PATIENTS RECEIVING CONTRAST/ GADOLINIUM INJECTION

Gadolinium-DTPA is a contrast agent that has been approved by the Food and Drug Administration for use in MRI scans. The side effects of Gadolinium contrast have been reported to include, but are not limited to, nausea, vomiting, headaches, and allergic reaction.

Do you have any of the following? (All must be checked YES or NO)

<u>YES</u>	<u>NO</u>	
_____	_____	Kidney Cancer/Failure/Insufficiency/Transplant
_____	_____	Diabetes
_____	_____	Hypertension
_____	_____	Liver Disease/Transplant (Hepatitis)
_____	_____	Pregnant/Breast-feeding
_____	_____	Medicine Allergies IF YES, Types _____

➔ Consult the technologist if you have any question or concern before you enter the MRI room.

I have read this consent form or have had it read to me. I have had the opportunity to ask questions about the use of Gadolinium and I consent to the use of Gadolinium in my case.

Patient's Signature _____

Date _____