Big Sky DIAGNOSTIC IMAGING OF BILLINGS

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MAGNETIC RESONANCE (MR) PROCEDURE SCREENING & CONSENT FORM

Name______________________________ DOB__________________ Weight_________________

Body Part to be Examined____________________________ Referring Physician_______________________

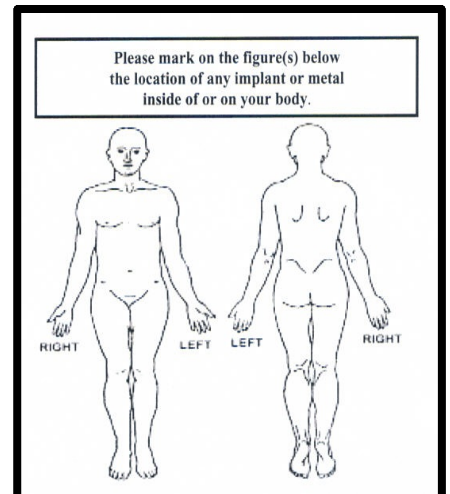
Reason for MRI/MRA (Symptoms and/or Condition)____

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.

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 allergies**?	Yes	No
10.	Are you pregnant or experiencing a late menstrual cycle?	Yes	No
11.	Are you currently breast feeding?	Yes	No

Please 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



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 I have the right to refuse the use of this contrast material.**

Signature of person completing form:____________________________________ **Date:**________________

Technologist's initials:_________ **Technologist's notes:**____