

MRI Part A - WHOLESALE

Height _____ Weight _____ lbs/kgs

Last Name: _____
First Name: _____
DOB: _____ Date: _____

The MRI room contains a very strong magnet and is ALWAYS on. You MUST remove all metallic objects. Hearing aids must be removed immediately before entering the MRI room. Failure to remove such items can result in serious damage to those items and/or injury to yourself and others. Please answer the following questions carefully.

Medical/Dental procedures in the past 24 hours?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
LVAD heart pump, pacemaker or pacer wires, defibrillator?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Implanted neurostimulator or TENS unit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Medication injection device (OnPro) or pump?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial heart valves/stents or aneurysm/vascular clips/grafts/shunts?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Breast tissue expander, metallic foreign body, bullet/shrapnel or any eye injury involving metal?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Small bowel endoscopy capsule or Vena Cava umbrella filter?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Recent colonoscopy or digestive system procedure involving surgical clips?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Catheter- drainage tube or temperature monitor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Prior ear, eye or brain surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hearing aids or Medication skin patches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pregnant? LMP: _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Joint Replacement or orthopedic/prosthetic device?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of Cancer? If yes, what type _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hair extensions/wig, braces, oral springs, removable dental work or anything held with magnets or pins?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tattoos/Body Piercings, Glitter/permanent makeup?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
DriWeave, Dri Fit or wicking clothing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Iron deficiency being treated with Feraheme?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
History of seizures or any recent falls? If yes, when? _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea in past 2-3 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Claustrophobia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anything in or on your body that you weren't born with?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

GENERAL CONSENT/ACKNOWLEDGEMENT

I consent to the ordered exam. I understand that I have the right to refuse or stop the exam at any time and I have the right to ask questions and discuss my concerns.

I have read the screening information and answered the above safety questions accurately, and I understand I MUST REMOVE ALL METAL prior to my MRI examination.

I acknowledge receipt of the FDA GBCA Medication Guide (if contrast is to be administered).

I have read and I understand, acknowledge and agree to the content of this General Consent form and have had my questions answered. I give my consent to receive electronic communications and survey invitations if applicable.

Patient Signature: _____ Date: _____ Time: _____

(Parent or Guardian if patient is a Minor or Incapacitated) Relationship: _____