



**BON SECOURS  
RICHMOND HEALTH SYSTEM**  
Bon Secours Richmond Health System

Place patient label inside box (if no patient label, complete below)

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

MR #: \_\_\_\_\_

**MRI HISTORY AND SCREENING SHEET (cont.)**

**Reason for today's test:** (Please indicate any symptoms you have and the exact location of any pain/numbness)

\_\_\_\_\_

PREVIOUS STUDIES YOU HAVE HAD RELATED TO TODAY'S PROBLEM:

<u>Body Part/Type of Exam</u>	<u>Where performed</u>	<u>Date</u>
_____	_____	_____
_____	_____	_____

**MR-Gadolinium Contrast Media Information**

Gadolinium is the key component of the contrast material most often given for Magnetic Resonance Exams. The intravenous use of Gadolinium improves image quality of the MRI and makes certain diseases easier to diagnose. Gadolinium is less likely to cause an allergic reaction, than the iodine based contrast given for computed tomography exams. Very rarely, patients are allergic to the Gadolinium based contrast materials and may experience hives, itchy eyes or skin, or nausea. These types of reactions are usually mild and are easily controlled with medications. It is extremely rare to have a severe reaction to Gadolinium.

Patients with kidney disease could experience a condition called Nephrogenic Systemic Fibrosis (NSF), which is a thickening of the skin and other organs. Although this is a rare complication, NSF can be life threatening. Gadolinium, typically is not given to those patients with severe kidney disease, although there may be rare exceptions at the discretion of the patient's physician. After your procedure has been completed, we recommend that you increase your fluid intake to help flush the contrast from your body.

The potential risks and benefits of Gadolinium have been explained to me. I understand that I may ask to speak with a physician before signing this form. My questions have been answered to my satisfaction.

I, \_\_\_\_\_, (printed name) agree to receive Gadolinium for my procedure if deemed necessary by my physician or the radiologist. I also attest that all of the information on this form is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MRI procedure that I am about to undergo. I understand that possible injury could result if I withhold vital information.

Person completing form:  Patient  Relative: \_\_\_\_\_  Nurse  MRI Tech  Other: \_\_\_\_\_

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

**This form will be scanned into your medical records**

**TO BE COMPLETED IN MRI**

All information was reviewed by:  MRI Tech  MRI Nurse  Radiologist  Other \_\_\_\_\_

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Scanning Technologist: \_\_\_\_\_

Personal belongings removed \_\_\_\_\_  Returned

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_



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- Memorial Regional Medical Center
- Richmond Community Hospital
- St. Francis Medical Center
- St. Mary's Hospital
- Bon Secours Health Source
- Reynolds Crossing Imaging Center
- Midlothian Imaging Center
- Watkins Imaging Center

Place patient label inside box (if no patient label, complete below)

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

MR #: \_\_\_\_\_

Weight: \_\_\_\_\_ Height: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

## MRI HISTORY AND SCREENING SHEET

The following items can interfere with the images and some may be hazardous to your safety. Please indicate if you have any of the following:

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| Brain surgery (of any kind) .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Intracranial Pressure bolt.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Aneurysm surgery.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever, in your lifetime, worked around metal or performed metal grinding or welding (including auto body work)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Any eye injuries involving metal .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Ear or eye surgery .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Body piercing.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing aids.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Any removable dental work .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Permanent eye liner or tattoos.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Seizures or epilepsy .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Spinal or ventricular shunt.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Neurostimulators (TENS unit), Spinal cord stimulator.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Vascular access port.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Greenfield filter, inferior vena cava filter .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Intravascular coil, filter, stent .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Implanted cardiac defibrillator.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Internal electrodes including pacing/stimulator wires .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiac pacemaker.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart valve replacement.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart bypass surgery.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Renal (kidney) or liver disease.....   | <input type="checkbox"/> | <input type="checkbox"/> |

Yes No

Please list any surgeries that you have had:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please list any allergies or reactions you have to any medications, latex, or adhesives:

\_\_\_\_\_

\_\_\_\_\_

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| Breast implant/tissue expander.....                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Pregnant, suspected pregnancy or breast feeding .....            | <input type="checkbox"/> | <input type="checkbox"/> |
| IUD, diaphragm or pessary .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Radiation seeds (e.g. cancer pt).....                            | <input type="checkbox"/> | <input type="checkbox"/> |
| Penile prosthesis or other type of prosthesis.....               | <input type="checkbox"/> | <input type="checkbox"/> |
| History of being wounded by bullets, shrapnel, etc. ....         | <input type="checkbox"/> | <input type="checkbox"/> |
| Ingested camera pill for endoscopy or endoscopic clips .....     | <input type="checkbox"/> | <input type="checkbox"/> |
| Surgical staples, clips or metallic sutures .....                | <input type="checkbox"/> | <input type="checkbox"/> |
| Metal plates, pins, screws, wires or mesh implants.....          | <input type="checkbox"/> | <input type="checkbox"/> |
| Joint replacement.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Any type of electronic, mechanical, or magnetic implant.....     | <input type="checkbox"/> | <input type="checkbox"/> |
| Any type of implant held in place by a magnet.....               | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever taken the medication Feraheme (Ferumoxytol).....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Medication patch .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Implanted medication pumps .....                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Insulin/infusion pump.....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Antimicrobial wound or burn dressing.....                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you claustrophobic? (afraid of small places) .....           | <input type="checkbox"/> | <input type="checkbox"/> |
| Respiratory problems .....                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Prior history of chemotherapy, radiation therapy or cancer ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Hypertension (high blood pressure).....                          | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood disorders including diabetes or anemia .....               | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had an MRI before?.....                            | <input type="checkbox"/> | <input type="checkbox"/> |

Yes No

### INPATIENTS ONLY: SEND MAR WITH PATIENTS

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| Endotracheal tube .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Swan-Ganz Catheter.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Extraventricular device .....                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| Arterial line transducer .....                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Foley catheter with temperature sensor and/or metal clamp ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Rectal probe .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Esophageal probe .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| Tracheotomy tube.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Guidewires.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| I.V. continuous drips .....                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| MAR on Chart.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| Screening sheet faxed to MRI.....                               | <input type="checkbox"/> | <input type="checkbox"/> |