

MRI Suite · 900 Terry Ave, Suite 100 · Seattle, WA 98104

MAIN: (206) 694-6665

**The following items may be hazardous or may interfere with the MRI examination.
Please read each item carefully before marking your response.**

REMOVE ALL PUMPS AND JEWELRY

<input type="checkbox"/>	<input type="checkbox"/>	Prior MRI examinations: type, date and place _____	<input type="checkbox"/>	<input type="checkbox"/>	EVER had metal fragments in your eyes
<input type="checkbox"/>	<input type="checkbox"/>	Any procedures or implants since last MRI scan	<input type="checkbox"/>	<input type="checkbox"/>	Any type of foreign body, shrapnel or bullet
<input type="checkbox"/>	<input type="checkbox"/>	Tattoos using metal oxides e.g., permanent eyeliner	<input type="checkbox"/>	<input type="checkbox"/>	Heart valve prosthesis—type: _____
<input type="checkbox"/>	<input type="checkbox"/>	Any type of surgical clip or staples	<input type="checkbox"/>	<input type="checkbox"/>	Aneurysm clip(s)—date: _____ hospital: _____
<input type="checkbox"/>	<input type="checkbox"/>	Vascular access port	<input type="checkbox"/>	<input type="checkbox"/>	Penile prosthesis—type: _____
<input type="checkbox"/>	<input type="checkbox"/>	Intraventricular shunt	<input type="checkbox"/>	<input type="checkbox"/>	Are you, or do you suspect pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Limb <input type="radio"/> Knee <input type="radio"/> Hip <input type="radio"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>	Intravascular coil, filter or stent—type & date implanted: _____
<input type="checkbox"/>	<input type="checkbox"/>	Any other implanted items (body piercings) Type/location: _____	<input type="checkbox"/>	<input type="checkbox"/>	Any type of ear implant—type: _____
<input type="checkbox"/>	<input type="checkbox"/>	<input type="radio"/> Dentures <input type="radio"/> Hearing Aid (MUST REMOVE)	<input type="checkbox"/>	<input type="checkbox"/>	Halo vest or metallic cervical fixation device
<input type="checkbox"/>	<input type="checkbox"/>	Diagnosed or treated for cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	Any other implanted items—type: _____
<input type="checkbox"/>	<input type="checkbox"/>	Transdermal patch (nicotine, nitroglycerine, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Are you claustrophobic
Weight: <input type="checkbox"/>	<input type="checkbox"/>	Must list weight—Maximum: 500 pounds. <i>Must be ambulatory</i>	<input type="checkbox"/>	<input type="checkbox"/>	Able to hold still on your back for at least 30 minutes
			<input type="checkbox"/>	<input type="checkbox"/>	Implanted pumps/drug infusion devices

Mark all blanks, if any marked yes, exam CANNOT be performed, cancel procedure and notify referring clinician.

<input type="checkbox"/>	<input type="checkbox"/>	Do you or have you had a cardiac pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Implanted cardiac defibrillator
<input type="checkbox"/>	<input type="checkbox"/>	Internal electrodes (e.g., retained pacer wires)
<input type="checkbox"/>	<input type="checkbox"/>	Electronic, mechanical, or magnetic implant
<input type="checkbox"/>	<input type="checkbox"/>	Implanted biostimulator or tens unit
<input type="checkbox"/>	<input type="checkbox"/>	Cochlear (inner ear) implant

PLEASE LIST BELOW ALL OPERATIONS & DATES:

**EXAM
DATE/TIME**

The MRI procedure you have been scheduled for may require the intravenous injection of a non-iodinated contrast solution. It is used to enhance the ability of MRI to facilitate diagnosis. While there are no known contraindications, mild side effects (nausea, headache) may occur. This solution is not the same used for CT scans, IVPs, or angiography.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of, and hereby give consent to have a Magnetic Resonance Image Scan.

Patient Signature: _____ Date: _____

Patient Printed Name: _____ Date: _____

RT/Initials: _____ Date: _____