

**Envision Imaging of North Fort Worth
PATIENT HISTORY AND SCREENING FORM FOR MRI**

Patient Name: _____ Sex: M F Weight _____ AGE _____

Clinical History: Please explain your medical problems that are the reason for having an MRI today: _____

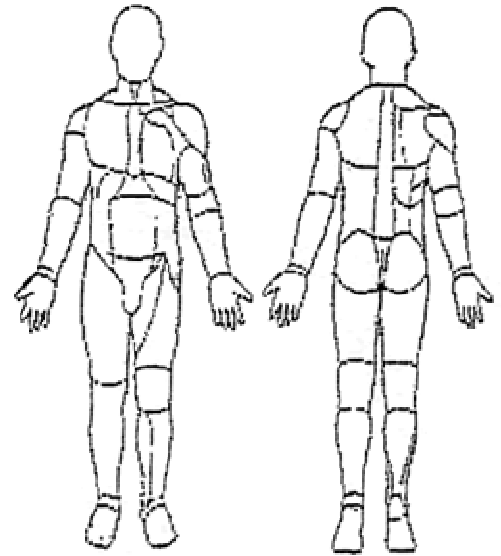
Have you had any previous X-ray, MRI or CAT scans related to this problem: YES [] NO []

WHERE and WHEN were previous scans performed? _____

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS OR ITEMS IN YOUR BODY?

- | | | |
|--|-----|----|
| Pacemaker | Yes | No |
| Ear/Cochlear Implant/Hearing Aid | Yes | No |
| Brain/Aneurysm Clips | Yes | No |
| Metal in eyes or ever had any removed | Yes | No |
| Metal fragments or shrapnel | Yes | No |
| Implanted electrical device | Yes | No |
| Neurostimulators | Yes | No |
| Stents or Heart valve | Yes | No |
| Dentures held in with magnets | Yes | No |
| Tattoos/Permanent Make-up or body piercing | Yes | No |
| Any other metal objects or implants _____ | | |
| List previous surgeries _____ | | |
| Have you ever been diagnosed with cancer | Yes | No |
| Have you ever had an injection of contrast for an MRI? | Yes | No |
| If yes, did you experience any of the following? | | |
| Hives | Yes | No |
| Shortness of breath | Yes | No |
| Are you diabetic? Yes No | | |
| Do you have any kidney or liver disease? Yes No | | |
| Have you ever had a liver transplant? Yes No | | |
| Other problems: Please explain _____ | | |

Please circle area(s) of pain



FEMALE PATIENTS ONLY:

- | | | |
|---|-----|----|
| Is there any possibility of pregnancy | Yes | No |
| When was the <i>first</i> day of your last menstrual cycle? _____ | | |
| What birth-control method are you currently using? _____ | | |
| Are you currently breast-feeding | Yes | No |

I have answered these questions to the best of my knowledge and understand the information presented to me.

Patient/Parent/Legal Guardian Signature _____ Date: _____

Technologist/Witness Signature _____

**ENVISION IMAGING OF NORTH FORT WORTH
INFORMED CONSENT FOR MRI
WITH OR WITHOUT CONTRAST INJECTION**

PATIENT NAME: _____

I, the undersigned, being either the patient named above or legally authorized representative of the patient named above, do hereby consent to the performance of medical diagnostic and imaging procedures at Envision Imaging of North Fort Worth Center on the terms and conditions more fully set out below. I understand that I have the right to be informed about the diagnostic imaging procedure being used so that I may make the decision whether or not to undergo the procedure.

1. **Consent to Imaging Procedure:** Your attending physician believes it beneficial for you to undergo a diagnostic imaging procedure known as magnetic resonance imaging (MRI) to obtain additional information that may aid in diagnosing and treating your medical condition. It has been explained to me that MRI does not use x-rays or radiation. Instead a magnetic field and radio waves are used to create an image of internal body structures. MRI is a painless procedure that only requires that you lie quietly on a padded table that gently glides you into the magnet. While the scanner is performing your scan, you will hear some humming and thumping sounds. These are normal and should not worry you. In some cases, a contrast agent may be injected into your vein in order to give a clearer image of the area being examined. The MRI study may be conducted without the injection of contrast, but the images may not be as helpful to the radiologist and your physician. Inform the technologist if you wish to refuse the contrast injection.
2. Because of the magnetic field and radio frequencies, people with a heart pacemaker, brain aneurysm clips, and some implanted metallic or electrical devices should not have an MRI. It is important that you inform the technologist if you have any of these metallic appliances. Please inform the technologist if you are pregnant or think that you may be pregnant.
3. **Potential Risks:** Anytime an injection is given there is the potential for bruising or swelling at the injection site. Occasionally, minor allergic reactions occur in the form of itching, sneezing, hives, swelling of the eyes, wheezing or nausea. These symptoms may require treatment with medication we have at hand. Rarely, a more serious reaction will occur. A radiologist will evaluate the situation and determine if additional medical treatment is necessary. Even though it is rare, medical statistics indicated that a fatality might occur from the injection of contrast. If you have had a reaction to a sickle cell anemia or kidney disorder, are pregnant or breast feeding, you **MUST** inform the technologist.
4. The benefit of this exam is to assist your physician with making a diagnosis. There may be other imaging alternatives, however your physician believes the MRI to be the best diagnostic test for you, after evaluating your symptoms and medical condition.

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to me. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, and the procedures to be used, and the risks and hazards involved. I understand its contents and have sufficient information to give this informed consent.

_____ DATE: _____ TIME: _____

Patient/Parent/Legal Guardian Signature

_____ DATE: _____ TIME: _____

Witness Signature

Not applicable to this exam				
_____	CC of Magnevist With a _____	@ _____	X _____	
Amount	In	Lot	GA & Needle Type	Time # of punctures
		Expiration Date: _____		
Site Location	By: _____			
Contrast Reaction	Yes	No	Physician Covering Contrast _____	
Expain _____				



PHONE: 817-741-0008
FAX: 817-741-3908

**PATIENT AUTHORIZATION
FOR THE RELEASE OF PROTECTED HEALTH INFORMATION
TO A CENTER**

PATIENT NAME: _____
DATE OF BIRTH: _____
ADDRESS: _____
PHONE: _____

In some cases, we need to review information contained in the medical records created for and about you by other physicians or healthcare facilities. In this setting it is normally to review images and reports acquired at a different imaging facility to help with your diagnosis.

By completing this form, you will authorize us to have access to such information.

Please list the Person/Facility that may release your medical information.

Information may be released to:



Information that may be released includes: *(please check one)*

- All information
- Only the following types of information. *(please specify)*

I authorize the release of the information specified to the above listed Center. I agree to pay reasonable charges for copies. I release all parties from any legal responsibility or liability for disclosures made pursuant to this authorization.

Patient Signature _____ **Date:** _____

