MedStar Georgetown University Hospital

Medstar Georgetown Radiology
MRI Safety Screening Form

MRN ___________

Patient Name: _______________________________________ Date of Birth: __________ Sex: ☐ Female ☐ Male

Height: ________ **Weight:** ________ Referring Physician: _________________ Date of Service: __________

Name of individual completing this form: _____________________________ Relation to patient: _______________

Contact information of individual completing this form: ____

Did you bring any previous imaging studies? NO ___ YES _____ If yes, what type: _____________________________

ARE YOU PREGNANT OR IS THERE ANY POSSIBILITY YOU MAY BE PREGNANT? NO _______YES _____________

Date of first day of last menstrual period: _____________________________________ ☐ Post Menopausal

Are you breastfeeding? NO_____ YES _________

LIST ALL PREVIOUS SURGERIES INCLUDING LAPAROSCOPIC OR ENDOSCOPIC PROCEDURES AND APPROX. DATES

____

____

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____

____

WHY ARE YOU HAVING THIS EXAMINATION?

____

____

LIST ALL KNOWN DRUG ALLERGIES: ____

LIST ALL CURRENT MEDICATIONS: ____

____

Are you claustrophobic? NO__ YES__Did your doctor prescribe a sedative for this exam? NO_____ YES _____

Do you have a motion disorder or breathing problem? NO___YES__; if yes, describe________________________

THE FOLLOWING ITEMS MAY PRESENT A SAFETY HAZARD OR INTERFERE WITH THE MRI/MRA STUDY. PLEASE CHECK ALL THAT APPLY.

	No	*Yes*		*No*	*Yes*
CARDIAC PACEMAKER, IMPLANTED CARDIAC DEFIBRILLATOR			**TRANSDERMAL MEDICATION PATCH**		
ANEURYSM CLIPS			**TATTOOS/ TATTOOED MAKEUP**		
HAVE YOU EVER HAD METAL IN YOUR EYES?			**BODY PIERCING**		
IMPLANTED NEUROSTIMULATOR			**ARTIFICIAL HEART VALVE**		
IMPLANTED DRUG INFUSION PUMP			**ARTIFICIAL LIMB OR JOINT**		
BULLETS, SHRAPNEL, METAL FRAGMENTS			**METAL SCREWS, PLATES**		
COCHLEAR, OTOLOGIC OR OTHER IMPLANT			**ORTHOPEDIC HARDWARE**		
PENILE IMPLANT			**PROSTHETIC EYE, OR EYE IMPLANTS**		
BREAST TISSUE EXPANDERS			**HARRINGTON RODS IN SPINE**		
METALLIC STENTS/COIL/FILTER/SHUNT			**HEARING AID (REMOVE)**		
ANY IV ACCESS PORT			**DENTURES/DENTAL IMPLANT**		
SURGICAL CLIPS, WIRES, STAPLES			**IUD/DIAPHRAGM/PESSARY**		

IF YES TO ANY OF THE QUESTIONS ABOVE, PROVIDE DETAILS:

____

____

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE: __________________ **DATE:** __________________ **Time**_________

RELATIONSHIP TO PATIENT: ____

INTAKE PERSONNEL__________________ **TECHNOLOGIST**__________________ **DATE:** ____________ **TIME:** _________

Medstar Georgetown Radiology MRI Safety Screening Form

HAVE YOU HAD PREVIOUS MRI'S/MRA'S WITH CONTRAST (GADOLINIUM)? NO _____ YES_____ UNSURE______
HAVE YOU EVER HAD AN ADVERSE OR ALLERGIC REACTION TO:
GADOLINIUM: NO____YES ______ UNSURE_______ OTHER MEDICATIONS: NO____ YES ______ UNSURE______
*If yes to any of the above, please describe:*____
____

HISTORY OF ASTHMA: NO____ YES________ UNSURE______________
ARE YOU CURRENTLY ON DIALYSIS? NO ___YES _____IF YES: HEMODIALYSIS _____ PERITONEAL______
PLEASE INDICATE IF ANY OF THE FOLLOWING APPLY:

	No	*Yes*
History of Kidney Disease (such as dialysis, renal cancer, renal transplant, single kidney, renal surgery)		
History of Diabetes (Sugar)		
History of High Blood Pressure requiring medication		

*******If you answered yes to any of these questions, please contact the MR staff before signing so we may better serve you.*******

Dear Patient,
Your Doctor has referred you to Georgetown Radiology for a Magnetic Resonance Imaging (MRI/MRA) scan. When doing MRI, we often use a contrast agent that is administered through a vein in your arm. This contrast material contains a rare earth element known as Gadolinium, a substance that shows up on your MRI study and highlights blood vessels and areas of increased blood flow. Gadolinium – based contrast agents are among the safest contrast agents used in Radiology.

Minor reactions to this injection may include: *headache, nausea, vomiting, and hives,* but these reactions occur in less than 3% of patients. More serious, potentially life threatening, "allergic" reactions are reported and may occur in 1:100,000-500,000 cases.

Please notify us if you are allergic to gadolinium contrast, on dialysis, have kidney failure, are pregnant, or are breastfeeding. ****These conditions may prevent us from giving you an MRI contrast agent.****

Your signature below indicates that you have read this form and answered questions correctly to the best of your knowledge.

PATIENT OR AUTHORIZED REPRESENTATIVE SIGNATURE: _______________________DATE: ________________ Time_________

RELATIONSHIP TO PATIENT: ____

TECHNOLOGIST___________________ DATE: ____________ TIME: __________

FOR OFFICIAL USE ONLY
eGFR: ________ Creatinine: ______________ Date Collected: ____________________
IV Site: __________________________________ Needle Gauge: _____________________
Gadavist: ______________ Eovist: ___________Multihance: _____________Other:_________________
Dose: ___________ ml's Lot #: ______________________ Exp: ______________________
Acc#: _________________________ MRN: _______________________________

Technologist's Signature: ____Date:____________ Time:______