IF YOU ARE PREGNANT, PLEASE NOTIFY THE TECHNOLOGIST IMMEDIATELY

Are you or could you be pregnant? YES NO _____(Initial) Date of last menstrual cycle ____/____/____

Are you currently breast feeding? YES NO _____(Initial) Patient Weight:_____

What symptoms or complaints brought you here?_____

_____

Please specify the location and duration of symptoms:_____

_____

Which side? RIGHT LEFT OTHER_____

PLEASE LIST ALL PRIOR SURGERIES: ☐ None Date

☐ _____ ____/____/____

☐ _____ ____/____/____

☐ _____ ____/____/____

Have you ever been diagnosed with cancer or serious illness? YES NO

If YES, What kind?_____

If YES, Have you had chemotherapy? YES NO Dates: ____/____/____

If YES, Have you had radiation therapy? YES NO Dates: ____/____/____

Do you have any allergies? YES NO If YES, Explain_____

Do you have any of the following conditions? _____

_____

BONE/NEUROSTIMULATOR WIRES	YES	NO	
PACEMAKER	YES	NO	
ANEURYSM CLIPS	YES	NO	
IMPLANTED CARDIAC DEFIBRILLATOR	YES	NO	
RETINAL TACK	YES	NO	If YES, what type?_____
HEARING AID	YES	NO	If YES, what kind?_____
COCHLEAR EAR	YES	NO	If YES, what kind?_____
HEART/CHEST SURGERY	YES	NO	If YES, what kind?_____
ARTHROSCOPIC	YES	NO	If YES, what kind?_____
TATTOO OR BODY PIERCING	YES	NO	If YES, what kind?_____
INTRAUTERINE DEVICE/PESSARY	YES	NO	If YES, what kind?_____
KIDNEY DYSFUNCTION	YES	NO	If YES, what kind?_____

Have you ever worked in a metal or machine shop? YES NO

Have you ever been struck in the eyes with metal shavings? YES NO

If YES, please explain:_____

Do you have bullets, shrapnel, or other foreign bodies on or within your body? YES NO

If YES, please explain:_____

Are you taking: Glucophage Metformin or Glucovance YES NO (Please circle and initial)

I attest that the information provided on this form is true to the best of my knowledge.

_____ _____

Signature of Patient or Guardian or Person Authorized to Consent for Patient Date

Technologist Notes:

_____

Tech Signature

PINNACLE HOSPITAL

MRI/MRA Questionnaire

updated 06/19 JL

place patient label here

I, _____, the patient named below, the parent of the minor patient named below or the legal guardian of the patient named below, authorize the performance upon the patient of the following diagnostic procedure(s):

☐ Computerized Tomography (CT)
The patient's physician has requested that Pinnacle Hospital perform a Computerized Tomography examination to obtain additional information. A CT examination is an imaging method that involves the use of X-ray radiation and computers to produce medically useful images of the body part of concern.

☐ Magnetic Resonance Imaging (MRI)
The patient's physician has requested that Pinnacle Hospital perform a Magnetic Resonance Imaging examination to obtain additional information. A MRI examination is an imaging method that uses magnetism, radio waves and computers to produce medically useful images of the body part of concern.

I understand that I have the right to be informed about my condition and the recommended diagnostic procedure to be used in order that I may make an informed decision whether or not to undergo the procedure after knowing the risks and hazards involved.

If the patient is pregnant, thinks she may be pregnant, is breastfeeding, I will inform Pinnacle Hospital personnel at once.

To properly study the area of concern during your CT or MRI examination, it is sometime necessary to intro an IV contrast agent into the body. Contrast agents enhance the visibility of certain tissues in the body and further assist in making a correct diagnosis. All the contrast agents used in our facility have been approved by the Food and Drug Administration and are considered safe.

Potential Risks: Anytime an injection is given, there is potential for pain, bleeding, bruising, swelling or infection at the injection site. Additional allergic reactions in response to the contrast agents may include hives, shortness of breath or difficulty swallowing. There have been rare instances of kidney failure, kidney damage or death after the administration of the contrast agent. *It is very important that you inform the technologist if the patient experiences any or has previously had a reaction to a contrast agent.*

An alternative to the procedures listed above may be an ultrasound, x-ray, nuclear medicine examination or no treatment.

I understand that the patient's physician has requested the CT or MRI to aid in the medical diagnosis and that the patient will benefit from this procedure, as this diagnostic test may offer information not available from other techniques.

I have read, understand and hereby consent to a CT / MRI (circle one) examination and the above conditions.

Patient (Please Print)	
Parent/ Legal Guardian Name (Please Print)	
Patient/Parent/Legal Guardian Signature	
Relationship if not Patient	
Date and Time	☐ A.M. ☐ P.M.
Witness Signature	

PINNACLE HOSPITAL

Consent for CT/MRI with IV Contrast Injection