Anaheim Hills Imaging Center

Patient Disclosure and Informed Consent

Name		Date of Birth	MRN:
Today's Date	Weight	Referring physician	

Your Doctor has requested that you have an Magnetic Resonance Imaging (MRI) examination to aid in your medical diagnosis. It is anticipated that you will benefit from this procedure, as this diagnostic imaging device may offer diagnostic information not available from other techniques.

PLEASE READ AND CIRCLE <u>YES</u> OR <u>NO</u> TO THE FOLLOWING QUESTIONS:

Do you have a pacemaker?	Yes	No	Have you had any surgeries? If yes, when & what?	Yes	No
Have you ever had brain surgery?	Yes	No	_____		
Have you ever had spine surgery?	Yes	No	Do you have a war injury or gunshot wound?	Yes	No
Do you have aneurysm clips, stents,	Yes	No	Have you ever gotten metal fragments in your eyes		
coils, or filters in your blood vessels?	Yes	No	from welding or grinding?	Yes	No
Have you ever had eye surgery or implants?	Yes	No	Do you have any implanted devices such as electrodes,		
Have you ever had ear surgery or implants?	Yes	No	Neurostimulators, heart valves, orthopedic implants		
Do you have a kidney/renal or liver disease	Yes	No	shunts, infusion pump, or prosthetic appliances?	Yes	No
Are you on dialysis?	Yes	No	Do you have any concealed body piercing?	Yes	No
Are you wearing a wig, hairpiece or hearing aid?	Yes	No	Have you ever had a contrast injection with any adverse effect?	Yes	No
Are you wearing dentures or a partial?	Yes	No	Are you claustrophobic?	Yes	No
Are you pregnant or nursing an infant?	Yes	No			

<u>PREGNANCY:</u>
The FDA has not established any criteria under which a pregnant woman may be scanned. Therefore, it is the policy of this facility that MR Imaging not be routinely performed on women with known or suspected pregnancy.

<u>CONTRAINDICATIONS:</u>
Since MRI is **electromagnetic**, you cannot undergo this procedure if you have any of the following: Cardiac pacemaker, cochlear implant, neurostimulators: metal fragments in the eye: implanted drug infusion pump; or aneurysm clips implanted in the brain.

***** Please inform us if you have any other implants not mentioned*****

<u>CONSENT:</u>
I confirm that the information I have provided is complete and accurate to the best of my knowledge. I have <u>read</u>, <u>understood</u>, and hereby give consent to this MRI examination.

_____ _____ _____
Patient Signature/Parent or Guardian if patient is a minor Date Witness

<u>CONTRAST CONSENT</u>:
Your physician has requested that an MRI be performed, which will necessitate the injection of a contrast media (Gadolinium) intravenously into your body. This consent form is to alert you to the rarely seen side effect of this enhancement agent, so that you will be informed prior to giving consent. The risk of a reaction is very small, but it still exists. These reactions range from skin irritation and skin rash to much more severe systemic reactions, i.e. anaphylactic shock, drug reaction, paralysis, nephrogenic systemic fibrosis (NSF/NFD), brain damage due to breathing or respiratory distress, and even death. If one should occur, I consent to the administration of any medications necessary in order to combat the effects of the reaction. Due to these risks, the IV enhancement agent is not injected unless there are personnel readily available to deal with the reaction. The purpose, benefits, and complications of the contrast procedure will be explained to your satisfaction before any injection takes place.

<u>ADDITIONAL CONTRAINDICATIONS FOR CONTRAST (IN ADDITION TO INFORMATION LISTED ABOVE):</u>
Patients with severe kidney insufficiency who receive gadolinium-based agent (MRI contrast) are at risk of developing a debilitating, and potentially fatal disease known as nephrogenic systemic fibrosis (NSF). In addition, patients prior to or just after a liver transplant, or those with chronic liver disease, are also at risk for developing NSF if the patient is experiencing kidney insufficiency of any severity.
I have <u>read</u>, <u>understood,</u> and hereby give consent to this MRI with intravenous contrast media injection.

_____ _____ _____
Patient Signature/Parent or Guardian if patient is a minor Date Witness