



Lake of the Woods
District Hospital

MAGNETIC RESONANCE IMAGING (MRI) SCREENING FORM

Last Name <i>(Legal)</i>		First Name <i>(Legal)</i>	
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB <i>(dd-Mon-yyyy)</i>	
Health Card #		Version	
Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Non-binary/Prefer not to disclose (X) <input type="checkbox"/> Unknown	

The following items may interfere with your Magnetic Resonance Imaging examination and some can potentially be **hazardous**.

Do you have drug allergies ? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(please list them)</i> :					
Patient Height			in/cm		Patient Weight
					lb./kg
Have you had MRI IV contrast before? <input type="checkbox"/> No <input type="checkbox"/> Yes			▶ Did you have a reaction? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Are you on dialysis? <input type="checkbox"/> No <input type="checkbox"/> Yes			Are you Claustrophobic? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Please indicate if you have the following		No	Yes	Please indicate if you have the following	
				No	Yes
Cardiac pacemaker				Eye prosthesis	
Implanted cardiac defibrillator <i>(ICD)</i>				Eyelid spring or wire	
Brain Aneurysm clip(s) or coil (s)				Penile prosthesis	
Electronic/Magnetic implant or device				IV access port, IVAD, PICC Line	
Implanted drug infusion device <i>(e.g., insulin, baclofen, chemo, pain meds)</i>				Intrauterine device <i>(IUD)</i> , diaphragm, pessary	
Endoscopy Clips <i>(e.g., Resolution Clip)</i>				Artificial joint/limb <i>(e.g., prosthesis, replacement)</i>	
Cardiac Pacing Leads/Wires				Bone/Joint pin, screw, nail, wire, plate	
Bone Growth/Neurostimulator				Glucose Monitoring Device <i>(sensor)</i>	
Coils, Filters, or Stents				Medication patch <i>(hormone, nicotine.)</i>	
Shunt <i>(renal, brain, heart, spine)</i>				Hearing aid	
Middle Ear Implants <i>(cochlea, stapes)</i>				Dentures or partial plates	
Swan-Ganz or thermodilution catheter				Tattoo or permanent makeup	
Heart valve prosthesis				Jewelry you cannot remove	
Tissue expanders <i>(e.g., breast)</i>				Have you ever had metal in your eyes?	
Surgical staples, clips, wire sutures				Was the metal removed by a doctor?	
Silver impregnated dressing				Are you pregnant?	
Shrapnel, bullet, or BB				Date of last menstrual period:	
Have you ever had any surgical procedures or operations? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(list all)</i>					Year
Type					
I have answered the above questions to the best of my ability. The MRI examination has been explained to me, and I have had my questions answered to my satisfaction.					
Signature of Patient or Guardian				Date <i>(dd-Mon-yyyy)</i>	
Witness/Technologist Name <i>(print)</i>				Witness/Technologist Signature	



Lake of the Woods
District Hospital

MAGNETIC RESONANCE IMAGING (MRI) CONTRAST FORM

Last Name <i>(Legal)</i>		First Name <i>(Legal)</i>	
Preferred Name <input type="checkbox"/> Last <input type="checkbox"/> First		DOB <i>(dd-Mon-yyyy)</i>	
Health Card #		Version	
Administrative Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		<input type="checkbox"/> Non-binary/Prefer not to disclose (X) <input type="checkbox"/> Unknown	

MRI Contrast Information - GADOLINIUM

You are having Magnetic Resonance Imaging (MRI) and it is important that you be informed about the procedure. You may require an injection of “dye” or contrast. The contrast will be given by an injection into a vein in your hand, arm or leg. The contrast makes certain diseases and important body structures more visible on MRI images.

Most people have no ill effects from the contrast. Sometimes mild reactions do occur but pass without treatment or respond quickly to medication. The risks or reactions associated with the contrast injection may include (*but are not limited to*) a “sweet” taste in your mouth, headache, nausea. Very rarely you may experience dizziness, vomiting, or an allergic reaction (*hives, watery eyes*).

Severe reactions can rarely occur that require medical treatment. These may include difficulty breathing, shock or heart failure.

If you feel any discomfort or experience any of these symptoms, please inform the nurse or the technologists performing your exam. The physicians caring for you are aware of these risks and have determined that the benefit of the diagnostic information outweighs the low risk.

Should you have any of these symptoms after your test, please contact your family physician immediately.

I authorize the radiologist and/or designated healthcare professional to perform the procedure with the administration of MRI contrast media as deemed necessary for the examination.

All potential risks of the contrast injection have been explained to me.

Signature of Patient or Guardian	Date <i>(dd-Mon-yyyy)</i>
Witness/Technologist Name <i>(print)</i>	Witness/Technologist Signature

MRI Staff to fill out if patient is on renal dialysis

Creatinine Level	GFR	Date Collected <i>(dd-Mon-yyyy)</i>
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Checked with Radiologist

Magnetic Resonance Imaging Use Only

Contrast injected by <i>(print)</i>		Time of injection <i>(hh:mm)</i>	
Contrast type	Amount		
Site of administration	Contrast Lot #	Expiry Date <i>(dd-Mon-yyyy)</i>	