



# BROADWAY IMAGING CENTER



## MRI scan Questionnaire

Are you pregnant? YES NO  
 Are you breast feeding? YES NO  
 Have you ever been a sheet metal worker? YES NO

### DO YOU HAVE?

✓ Pacemaker YES NO  
 ✓ Neuromuscular Stimulators YES NO  
 ✓ Metal surgical clips YES NO  
 ✓ Metal prosthesis YES NO  
 ✓ Metal pins or plates YES NO  
 ✓ Orbital prosthesis YES NO  
 ✓ Inner-ear prosthesis YES NO  
 ✓ Any other implants, IUD YES NO  
 ✓ Dentures YES NO  
 ✓ Shrapnel wounds YES NO

### MEDICAL HISTORY

✓ Do you have a history of claustrophobia? YES NO  
 ✓ Have you had a brain surgery? YES NO  
 ✓ Have you had a cardiac surgery? YES NO  
 ✓ Have you had any other surgery? YES NO  
 ✓ Do you have an anemia? YES NO

**For Office Notes**

I have read and answered the above questions to the best of my knowledge

### MRI DESCRIPTION

Magnetic resonance imaging is a method of producing pictures of the body by placing one into a large magnet. You will be asked to remove all metal objects before entering the MRI scanner room. Once in the scanner room you will be asked to lie on a table and an imaging coil will be placed near the area of the body to be examined. The total examination will take about 45 minutes. During that time, you will be able to communicate with the technicians performing the study.

To complete your examination an intravenous injection of a magnetic resonance contrast agent (containing gadolinium, not iodine) may be necessary. The procedure is simple with a few side effects reported worldwide. A few patients have experienced headaches, or nausea with the injection.

### CONSENT TO MRI PROCEDURE

You are making a decision whether or not to consent to the performance of the procedure that is described. Your signature on this informed consent form indicates that:

- ✓ you have read and understood the information provided on this form,
- ✓ you have been verbally informed about this procedure,
- ✓ you have had a chance to ask questions,
- ✓ you have received all of the information you desire concerning this procedure and
- ✓ you authorize consent to the performance of this procedure.-

I understand that the results of my study are confidential and will be disclosed only with my doctor's or with my permission. All of my questions have been answered.

Patient Name \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_

Witness Name \_\_\_\_\_ Date \_\_\_\_\_ Signature \_\_\_\_\_