



STATEMENT OF CONSENT FOR MAGNETIC RESONANCE IMAGING (MRI)

Date: _____ Weight: _____

Name (Legal): _____ Date of Birth: _____

Exam/Scan: _____

Magnetic Resonance Imaging (MRI) is a method of producing pictures of the body by placing you in a large magnet. I understand I will be asked to remove all metal objects before entering the magnetic resonance scanner room. Once in the scanner room, I 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 may take up to an hour. During that time, I will be in verbal communication with the technologist performing the study.

To complete your examination, an intravenous injection of a magnetic resonance contrast agent (Gadolinium, not iodine) may be necessary. The procedure is simple with few side effects reported worldwide. A few patients have experienced transient headache or nausea with the injection. Please inform the staff if you are pregnant, breast-feeding, have any disease that affects the red blood cells (i.e. sickle cell anemia) or if you have severe anemia.

Please mark below:

Pacemaker or Artificial Valve? [] Yes [] No If Female, Pregnant? [] Yes [] No

Have you ever had Brain Surgery? Or Inner Ear Surgery? [] Yes [] No If yes, how far along? _____ Aneurysm Clips? [] Yes [] No

If yes, date: _____ Explain: _____

Implanted Electronic Device? [] Yes [] No Tattoos or Tattooed Eyeliner? [] Yes [] No

Cochlear Implant? [] Yes [] No

Do you have a Metal Fragment in An Eye or Near the Spine? [] Yes [] No Metal Hardware in Mouth? (braces, etc.) [] Yes [] No

Are you Claustrophobic? [] Yes [] No Breast Implant with metal expanders [] Yes [] No

History of Kidney Disease? [] Yes [] No History of Diabetes? [] Yes [] No

Privacy Policy: I understand that the results of my study are confidential and will be disclosed only to my referring physician. A written "release of medical records consent" must be signed by me if I would like my results to be provided to additional physicians other than my direct referring physician.

Disclosure: I understand that having certain types of metal in my body can be hazardous to my health and may interfere with the examination.

Certification: I certify and understand that I personally completed this form and that all above information contained above is true, correct and complete to the best of my knowledge.

Patient or Guardians Signature _____ Date: _____