Sound Radiology
ABN 72 116 377 201
257 Fullarton Road, Parkside SA 5063
PO Box 675, Fullarton SA 5063
Ph 08 8357 8855
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PATIENT INFORMATION FORM

MRI Patient Safety and Consent

ALL patients are required to complete this form prior to having their MRI scan. Please note the MRI machine is ALWAYS ON please remove ALL metallic objects in or on your body in preparation for your scan.

Patient Name (print) _____

Date of birth _____/_____/_____ **Weight** _____ **Gender** **M** ☐ **F** ☐

Is English your SECOND language? ……..…….....**YES** ☐ **NO** ☐

PLEASE CAREFULLY READ AND ANSWER THE FOLLOWING QUESTIONS BY CIRCLING ***YES OR NO***
DO YOU HAVE OR EVER HAD THE FOLLOWING?

Previous MRI? *If yes, what region of the body?*	YES NO
Surgery to your head, heart, ears or eyes? *If yes, please describe.*	YES NO
Metal in your eyes? (metal grinding) *If yes, was it removed?*	YES NO
Surgery/procedures in the last 6 weeks? *If yes, please describe.*	YES NO
Surgery/procedures elsewhere on your body? *If yes, please describe.*	YES NO

Heart attack	YES	NO	Stroke	YES	NO
Brain aneurysm clips/coils	YES	NO	Stapes implant	YES	NO
Pacemaker, defibrillator or cardiac pacing wires	YES	NO	Heart valve replacements or stents	YES	NO
Dentures/Plates/Braces	YES	NO	Radiation seeds or implants	YES	NO
Metal screws, pins, plates	YES	NO	Prosthetic joints or limbs	YES	NO
Cochlear implants	YES	NO	Neurostimulator or biostimulator	YES	NO
Medication skin patches or metallic dressing	YES	NO	Any type of prosthesis (eye, penile)	YES	NO
Tattoo or permanent makeup	YES	NO	Shrapnel/ bullet wounds	YES	NO
Body piercing (excluding earrings)	YES	NO	Hearing aids	YES	NO
Hypertension	YES	NO	Asthma	YES	NO
Any history of kidney disease	YES	NO	Diabetes	YES	NO
Any recent blood tests for kidney function? *If yes, where?*	YES	NO	Any form of cancer? *If yes, please indicate the affected area:*	YES	NO

Please list any allergies:

FEMALE PATIENTS ONLY

Do you have an intra-uterine contraceptive device?	YES NO
Are you pregnant?	YES NO
Are you breast-feeding?	YES NO

Please turn over

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MRI contrast injection:

Some MRI examinations may require you to have an injection of an intravenous contrast or dye (Gadolinium). MRI contrast is administered through a small plastic cannula, which is placed into a vein in your arm. The administration of this contrast for imaging is considered to be very safe.

Occasionally (1 in 1000 injections) mild allergic reactions such as a rash, hives, headache, nausea or sneezing can occur and again these are usually developed at the time of the procedure. Less commonly, more severe reactions can occur, including shock and circulatory disturbance. Severe life-threatening reactions up to and including death have occurred but are very uncommon. The chance of this happening is of the order of 1 in 500,000 injections. We have the equipment and medications available to treat any serious reaction.

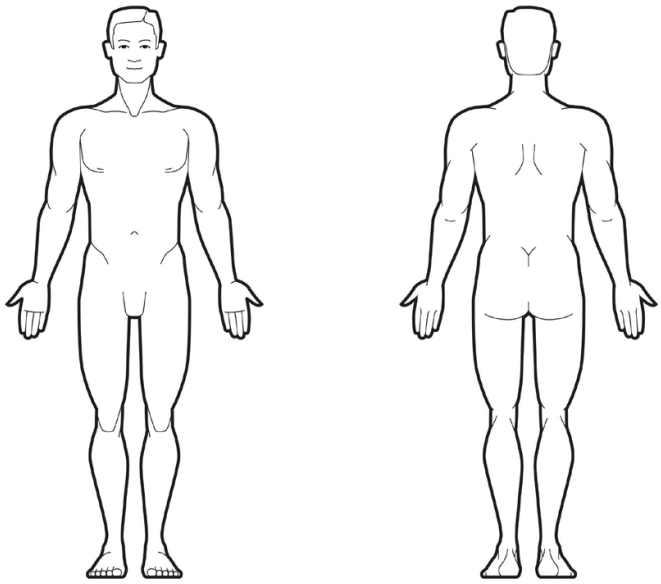
Having an allergy to another drug, food or insect bite causes a very minor but usually insignificant increase in the risk of an allergic reaction to intravenous contrast medium. If you have had intravenous contrast before without any adverse response, the chance of having a reaction to a subsequent injection is reduced but not zero.

Have you ever had an intravenous contrast? (Such as CT contrast or Gadolinium) ……..……..**YES** ☐ **NO** ☐

Have you ever had a **REACTION** to intravenous contrast? (Such as CT contrast or Gadolinium) ……..**YES** ☐ **NO** ☐

If so, please describe ……

Please indicate on the image below where your pain is (if applicable)



Please provide any relevant detail of trauma or surgery to the area:

……

……

……

CONSENT:

I have filled in this safety and consent form with correct information to the best of my knowledge. I understand and have been given the opportunity to ask any questions and give consent for this procedure, with an injection of contrast if required, to be performed.

Name (print) _____ **Signature** _____ **Date** ____/____/_____

Form completed by: Patient Parent / Guardian / Relative Staff

MRI TECHNOLOGIST _____ **Signature** _____ **Date** ____/____/_____

STAFF USE ONLY

Pre MRI imaging performed: _____ Reviewed by Dr. ……