NORTHLAND
IMAGING SERVICES

Patient Name: _____ DOB: ____/____/____
MR# _____

INFORMED CONSENT FOR MRI WITH OR WITHOUT CONTRAST INJECTION

TO THE PATIENT: You have the right to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you. It is so that you may choose to give or withhold your consent to the procedure. If you are pregnant or think that you may be pregnant, please inform the MRI personnel/staff at once. It is very important that you inform the technologist if you have a pacemaker, aneurysm clips or other implanted metallic or electric devised.

Your physician has requested that we perform a magnetic resonance imaging (MRI) examination. MRI uses a magnetic field and radio waves to produce an image of the internal body parts being examined. MRI is painless, and does not use x-rays or radiation. The only discomfort involved may be to lie quietly in a space that can be confining during the study. Because MRI is a diagnostic procedure, it provides information that may aid your physician in diagnosing and treating your medical condition. Without the MRI scan, accurate diagnosis and proper treatment may be delayed.

As part of your MRI, a contrast agent may be injected into your vein or a joint in order to produce better images of the part of your body that is being examined. The MRI procedure may be conducted without the injection of the contrast agent, but the images may not be as helpful to the radiologist and your physician. If you wish to refuse the contrast injection, inform the technologist and the MRI will be conducted without the contrast agent.

Potential risks – The following complications are possible: anytime an injection is given there is potential for pain, bleeding, bruising, swelling, or injury at the injection site. MRI exams requiring contrast may result in a mild headache, nausea, itching or other vague symptoms for a short time after the injection. Additional allergic reactions in response to the contrast agent may include: hives, shortness of breath or difficulty swallowing. There have been rare instances of death after the administration of the contrast agent. **It is very important that you inform the technologist if you experience any of the conditions mentioned in the form while with Northland Imaging Services, and that you seek prompt medical supervision/treatment if the conditions mentioned in the form occur after you have left the medical facility**.

NOTE TO PATIENT: If you have previously had a reaction to contrast injection such as hives, severe itching, shortness of breath, and/or any significant reaction requiring hospitalization, a history of asthma, or other allergic reactions, any history of anemia, sickle cell anemia, kidney disorder, are pregnant or breast-feeding, you MUST inform the technologist. The safety of contrast for children under the age of two (2) has not been established.

There may be other Imaging alternatives, however, your physician believes the MRI to be the best diagnostic test for you, considering your symptoms and condition. The benefit of this exam is to assist your physician with a diagnosis.

I (WE) CERTIFY THIS FORM HAS BEEN FULLY EXPLAINED TO ME (US). THAT I (WE) HAVE READ IT OR HAVE HAD IT READ TO ME (US). THAT THE BLANK SPACES HAVE BEEN FILLED IN, AND THAT I (WE) UNDERSTAND ITS CONTENTS.

I (WE) HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS ABOUT MY CONDITION, ALTERNATIVE FORMS OF TREATMENT OR ANESTHESIA/SEDATION IF REQUIRED, AS WELL AS THE PROCEDURES TO BE USED, AND THE RISKS AND HAZARDS INVOLVED, AND I (WE) HAVE SUFFICIENT INFORMATION TO GIVE THIS INFORMED CONSENT.

_____ ____/____/____ _____
Patient/Parent/Legal Guardian Date Time

_____
Witness

NORTHLAND
IMAGING SERVICES

MAGNETIC RESONANCE (MR) PROCEDURE

Date ___/___/___ Facility_____ X Ray or MR#_____
Name _____Age _____ Height _____ Weight _____
Date of Birth ____/____/____
Referring Physician _____ Telephone (____) ____-_____
Reason for MRI and/or Symptoms _____ Body Part to be Examined _____

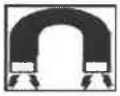
Are You Claustrophobic? No ___ Yes ___	**Can you lie still for 30 minutes? No ___ Yes ___**
If you are claustrophobic, arrangements must be made with your doctor for some form of sedation to be taken **before** your scan.	If you cannot lie still for 45 minutes due to pain or a chronic condition, please take any prescribed or over the counter pain relievers **before** your scan.

1. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? No ___ Yes ___
2. Do you have anemia or any disease that affects your blood: a history of renal (kidney) disease, renal (kidney) failure or transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, or seizures? No ___ Yes ___
If yes, please describe:_____

FOR FEMALE PATIENTS:

3. Are you pregnant or experiencing a late menstrual period? No ___ Yes ___ Trimester: _____
4. Are you currently breastfeeding? No ___ Yes ___

⚠ IMPORTANT INSTRUCTIONS ⚠



Before entering the MRI environment or MR system room, you must REMOVE all METALLIC OBJECTS

Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object.
Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room as the MRI system is always on.

PLEASE INDICATE IF YOU HAVE ANY OF THE FOLLOWING:

Yes / No Cardiac pacemaker
Yes / No Aneurysm clip(s)
Yes / No Spinal cord stimulator
Yes / No Neurostimulation system
Yes / No Metallic stent, filter, or coil
Yes / No Heart valve prosthesis
Yes / No Wire mesh implant
Yes / No Dentures or partial plates
Yes / No Joint replacement (hip, knee)
Yes / No Internal electrodes or wires
Yes / No Other implant _____
Yes / No Claustrophobia
Yes / No History of MRSA
Yes / No Electronic implant or device
Yes / No Hearing Aid
Yes / No Radiation seeds or implants
Yes / No Tissue expander (e.g., breast)
Yes / No Body piercing jewelry
Yes / No Any type of prosthesis (eye, etc.)

Yes / No Implanted cardioverter defibrillator (ICD)
Yes / No Cochlear, otologic, or other ear implant
Yes / No Bone growth/bone fusion stimulator
Yes / No Medication patch (Nicotine, Nitroglycerine)
Yes / No Artificial or prosthetic limb
Yes / No Shunt (spinal or intraventricular)
Yes / No Swan-Ganz or thermodilution catheter
Yes / No Injury to eye involving metal
Yes / No IUD, diaphragm, or pessary
Yes / No Surgical staples, clips, or metallic sutures
Yes / No Any metallic fragment or foreign body
Yes / No Bone/joint pin, screw, nail, wire, plate, etc.
Yes / No Open Wound: Describe:_____
Yes / No Eyelid spring or wire
Yes / No Implanted drug infusion device
Yes / No Vascular access port and/or catheter
Yes/ No Tattoo or permanent makeup
Yes / No Magnetically-activated implant or device
Yes / No Lower Back Surgery

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Signature of Person Completing Form	Patient/Relative	Date
TECHNOLOGIST SIGNATURE	MRI Technologist	Date
Issues/Comments:		

Revision 09.07.2017