MRI PATIENT CONSENT FORM

PATIENT NAME:_____ PATIENT#_____

YOU HAVE THE RIGHT TO BE INFORMED ABOUT YOUR CONDITION AND THE RECOMMENDED DIAGNOSTIC PROCEDURE TO BE USED, SO THAT YOU MAY MAKE THE DECISION WHETHER OR NOT TO UNDERGO THIS PROCEDURE AFTER KNOWING THE RISKS AND HAZARDS INVOLVED. THIS DISCLOSURE IS NOT MEANT TO SCARE OR ALARM YOU. IT IS SO THAT YOU CHOOSE TO GIVE OR WITHOLD YOUR CONSENT TO THE PROCEDURE.

IF YOU ARE PREGNANT OR THINK THAT YOU MIGHT BE PREGNANT, PLEASE INFORM THE CENTER PERSONNEL AT ONCE. IT IS VERY IMPORTANT THAT YOU INFORM THE TECHNOLOGIST IF YOU HAVE HEART VALVES, A PACE MAKER, ANEURYSM CLIPS, OR OTHER IMPLANTED METAL ELECTRICAL DEVICES.

YOUR PHYSICIAN HAS REQUESTED A MAGNETIC RESONANCE IMAGING (MRI) EXAMINATION TO OBTAIN ADDITIONAL INFORMATION. MRI USES A MAGNETIC FIELD, AND RADIO WAVES TO PRODUCE IMAGES OF THE BODY PART BEING EXAMINED. MRI DOES NOT USE X- RAYS OR RADIATION AND IS PAINLESS. SOME SCANNERS MAY PRODUCE LOUD REPETITIVE NOISES THROUGHT THE PROCEDURE. HEADPHONES WILL BE PROVIDED AS NEEDED.

A CONTRAST AGENT (FLUID) MAY BE INJECTED IN YOUR VEIN, AS PART OF YOUR MRI, TO PROVIDE BETTER IMAGES OF THE PART OF THE BODY BEING EXAMINED.

POTENTIAL RISKS: THE FOLLOWING COMPLICATIONS ARE POSSIBLE ANYTIME AN INJECTION IS GIVEN: POTENTIAL FOR PAIN, BLEEDING, BRUSING, OR SWELLING AT THE INJECTION SITE. MRI EXAMS THAT REQUIRE CONTRAST MAY RESULT IN 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 THIS FORM.

IF YOU HAVE PREVIOUSLY HAD A REACTION TO A CONTRAST INJECTION SUCH AS HIVES, SHORTNESS OF BREATH, ANY SIGNIFICANT REACTION REQUIRING HOSPITILIZATION, A HISTORY OF ASTHMA, OR OTHER ALLERGIC CONDITIONS, ANY HISTORY OF ANEMIA, SICKLE CELL ANEMIA, OR KIDNEY DISORDER, OR IF YOU ARE BREAST FEEDING YOU MUST INFORM THE TECHNOLOGIST. THE SAFETY OF CONTRAST IN CHILDREN UNDER 2 YEARS OF AGE HAS NOT BEEN ESTABLISHED.

THERE MAY BE OTHER IMAGING ALTERNATIVES; HOWEVER YOUR PHYSICIAN BELIVES THIS IS 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 CERTIFY THIS FORM HAS BEEN FULLY EXPLAINED TO ME THAT I HAVE READ IT, OR HAVE HAD IT READTO ME, THAT THE BLANK SPACES HAVE BEEN FILLED IN, AND THAT I UNDERSTAND ITS CONTENTS.

I HAVE BEEN GIVEN AN OPPORTUNITY TO ASK QUESTIONS ABOUT MY CONDITION, ALTERNATIVE FORMS OF TREATMENT/DIAGNOSIS, THE PROCEDURES TO BE USED, AND THE RISKS AND HAZARDS INVOLVED, AND I HAVE SUFFICIENT INFORMATION TO GIVE THIS INFORMED CONSENT.

_____ _____ _____

PATIENT/ PARENT/ LEGAL GUARDIAN SIGNATURE DATE TIME

_____ _____ _____

WITNESS SIGNATURE DATE TIME