Comprehensive Diagnostic Imaging & Radiology

DOB: ________________ Date: _____________ MRN: ___________

PATIENT CONSENT FOR MAGNETIC RESONANCE IMAGING

Name: ______________________________________ Exam: ___________________________________

An MRI scan uses a strong magnetic field and radio waves to study the anatomy of body tissues. The procedure has been used in chemistry since the 1940's. In the past decade, it has been applied to the study of the human body; the device has been reviewed by the Food and Drug Administration for safety and effectiveness, and approved for use on 9/25/84.

PLEASE CHECK IF YOU HAVE ANY OF THE FOLLOWING:

___ Cardiac Pacemaker ___ Brain Clips ___ Aortic Clips ___ Shunts

___ Carotid Clips ___ Ear surgery ___ Artificial Heart Valve ___ Pregnant

___ Insulin Pump ___ Penile Implant ___ Shrapnel (Bullets) ___ Dentures

___ Cardiac Stents ___ Wire Sutures ___ Metal Chips in Eyes or under your skin

___ Cochlear Implant ___ Brain surgery ___ Heart surgery ___ Eye surgery

___ Hearing Aid ___ Retinal tack ___ Stimulators of any kind ___ Tattoo

___ Body piercing ___ Have you ever worked with metal ___ Permanent Eyeliner/Eye Brow

___ Fractured Bones Treated with: Metal Rods, Plates, Screws, Nails, or Clips ___ False Magnetic Eye Lashes

___ Jewelry such as earrings that cannot be removed by you or require a tool to remove ___ Joint Replacement

___ Monitor **OF ANY KIND** (i.e. Insulin, Heart etc.) placed on or under your skin ___ IUD

___ Have you had a colonoscopy or upper endoscopy within the last 6 weeks where a biopsy was done or a tissue sample was taken that required the use of a clip

IF YES TO ANY OF THE ABOVE, PLEASE TELL THE TECHNOLOGIST IMMEDIATELY. DO NOT ENTER THE SCAN ROOM

IF COMPLETING THIS FORM ON LINE, AND YOU ANSWERED YES TO ANY OF THE ABOVE, PLEASE CALL HARTSDALE IMAGING IMMEDIATELY AT (914) 761-4030. WE WILL ADVISE YOU IF ANY ADDITIONAL INFORMATION IS REQUIRED.

INFORMED CONSENT

I have read the foregoing and understand that I will be asked to lie on a table which will slide into a powerful magnet while the necessary data is being obtained. The exam will be interrupted or terminated upon my request. I understand that I may receive a copy of this consent form if I so desire. By signing the consent, I acknowledge that I have read and understand its contents and I agreed to this examination.

Patient/Parent/Guardian: ______________________________________ Date: _______________________

If not Patient Indicate Relationship: ____

Technologist: ____ Date: _______________________