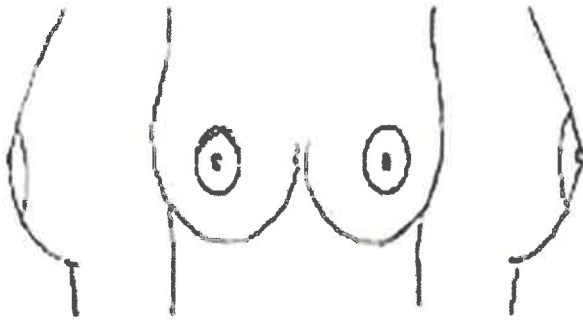


NAME _____ **AGE** _____ **HEIGHT** _____ **WEIGHT** _____

BREAST MRI SAFETY/SCREENING FORM

Please mark any areas of concern



Right Breast

Left Breast

Any chance of pregnancy? Yes ___ No ___ LMP _____

Are you breast-feeding? Yes ___ No ___

Do you think you may be claustrophobic? Yes ___ No ___

MRI is simple, safe, and painless. However, because we use strong magnets during the procedure, metal objects in your body may be hazardous or cause interference. Please provide us with **IMPORTANT** information before entering the MRI department.

Do you have any of the following items in your body:

- | | |
|---|----------------|
| Pacemaker | Yes ___ No ___ |
| Implanted electrical device | Yes ___ No ___ |
| Ear/Cochlear implant | Yes ___ No ___ |
| Neurostimulators | Yes ___ No ___ |
| Brain/Aneurysm clips | Yes ___ No ___ |
| Stents | Yes ___ No ___ |
| Metal in eyes | Yes ___ No ___ |
| Tissue expander | Yes ___ No ___ |
| Metal fragments or shrapnel | Yes ___ No ___ |
| Magnetic dental implants | Yes ___ No ___ |
| Any other metal objects or implants | _____ |
| If known, please give name and date of implant | _____ |

I hereby give my consent to Imaging Specialists of Charleston to perform an MRI as ordered by my physician. Sometimes MRI requires an injection of contrast, MRI contrast (Gadolinium) is administered through a small needle placed into a vein. During the administration of MRI contrast (Gadolinium), you may experience the sensation of contrast being injected, which is normal and expected. MRI contrast (Gadolinium) is quite safe, however as with all medications, there is a slight risk of allergic reaction. The physicians and staff in the MRI department are trained to respond to any emergency situation that may develop. In addition, we use the safest MRI contrast, which our physicians believe is best for you.

I have read and understand the above information and my questions have been answered. I consent to the use of paramagnetic contrast.

Signature: _____ **Relationship to pt:** _____ **Date:** _____

*****TECHNOLOGIST SECTION ONLY*****

<p>Have you ever had an MRI? Yes/No</p> <p>Have you ever had an injection of contrast for MRI? Yes/No</p> <p>**Last MRI breast ___/___/___ Where? _____</p> <p>**Last mammo ___/___/___ Where? _____</p> <p>**Last breast U/S ___/___/___ Where? _____</p>	<p>Do you have a personal history of breast/ovarian cancer? Yes/No</p> <p>Do you have a family history of breast/ovarian cancer? Yes/No</p> <p>Have you been tested for BRCA 1 or 2? Yes/No</p> <p>If yes, were you <i>positive/negative</i></p>
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Symptoms (circle one, if applies): breast pain/breast lump/nipple discharge/skin changes [Right/Left/Bilat]

HX of breast biopsy: _____ **HX of breast surgery:** _____

Other cancer: _____

Other surgery: _____

RENAL FAILURE: YES or NO **CONTRAST:** _____ **MAGNEVIST:** _____ **MULTIHANCE:** _____ **SEDATION:** _____