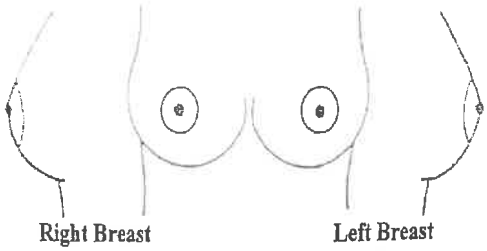
NAME_____ **AGE**_____ **WEIGHT**_____

BREAST MRI SAFETY/SCREENING FORM

Please mark any areas of concern:



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**********

Have you ever had an MRI? *Yes/ No*

Have you ever had an injection of contrast for MRI? *Yes/No*

****Last MRI breast___/___/___ Where?_____**

****Last mammo ___/___/___ Where?_____**

****Last breast U/S___/___/___ Where?_____**

Do you have a personal history of breast/ovarian cancer? *Yes/No*

Do you have a family history of breast/ovarian cancer? *Yes/No*

Have you been tested for BRCA 1 OR 2? *Yes/No*

If yes, were you *positive/negative*?

Symptoms (circle one, if applies): ***Breast pain/breast lump/nipple discharge/skin changes*** **[RIGHT /LEFT/ BILATERAL]**

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

Other Cancer:_____

Other Surgery:_____

Creatinine:_____ **GFR:**_____ **Contrast:**_____ **Magnevist:**_____ **Multihance:**_____ **Sedation:**_____