



MRI CONTRAST PATIENT PROFILE

PATIENT'S NAME Last	First

DATE OF STUDY	SEX	WEIGHT lbs.	DATE OF BIRTH	AGE
DIAGNOSIS or SYMPTOMS (Reason for this exam)				

Have you ever had X-Ray Contrast (Dye) injected before? <input type="radio"/> Yes <input type="radio"/> No	Are you pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Unsure LMP <input style="width: 50px;" type="text"/>
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In order to perform the exam your physician has requested, you will be given an injection of contrast containing gadolinium-related products. The contrast does NOT contain iodine. The contrast media allows the radiologist to better visualize the area of study.

Gadolinium based contrast media is considered very safe. Any injection carries slight risk of harm including injury to a nerve, artery or vein, infection, or reaction to the contrast being injected. Rarely, a patient will have a mild reaction to the contrast agent and develop sneezing or hives. Uncommonly a serious reaction occurs. The physicians and staff are trained to treat these reactions. Very rarely death has occurred related to contrast administration. A YES answer to any of the questions below does not mean that you will get a contrast reaction as the overwhelming majority of all patients do not.

The greatest risk is a metallic object flying through the air toward the magnet and hitting you. To reduce this risk we require that all people involved with the study remove all metal from their clothing and all metal objects from their pockets. No metal objects are allowed to be brought into the magnet room at any time. In addition, once you are in the magnet, the door to the room will be closed so that no one inadvertently walks into the magnet.

If you have any questions about the contrast agent, risks, reactions, or the procedure itself, please ask the x-ray technologist or the physician.

Did you have any of the following reactions after a prior contrast injection?

<input type="checkbox"/> Rash or hives	<input type="checkbox"/> Fainting	<input type="checkbox"/> Medical Treatment Required
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Flushing	<input type="checkbox"/> No Problems
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Other <input style="width: 100px;" type="text"/>

Food Allergies: Shellfish None Other

Drug Allergies: Iodine Antibiotics Other

I UNDERSTAND AND ACCEPT THE RISKS Yes No

Patient Signature	Date
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PROCEDURE DATA			
This Section to be Completed by Technologist/Nurse			
<input type="checkbox"/> Signed consent on chart	IV Access Site Gauge <input style="width: 50px;" type="text"/> Location <input style="width: 100px;" type="text"/>	Contrast Media	Premedicated
<input type="checkbox"/> Order verified	1st Attempt <input type="radio"/> Yes <input type="radio"/> No Other attempted sites <input style="width: 100px;" type="text"/>	<input style="width: 50px;" type="text"/> cc's using power injection	<input type="checkbox"/> None <input type="checkbox"/> Steroids <input type="checkbox"/> Benadryl

Patient Education

Provided To Patient Family Other Communication/Language Barriers - Explain

Complication Yes No Response Treatment

CONTRAST PATIENT PROFILE E1813 (Revised 12/16/2005)	Completed by: <input style="width: 100px;" type="text"/> Tech/Nurse Signature: <input style="width: 100px;" type="text"/>
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