I hereby authorize the performance upon me of the procedure known as **Magnetic Resonance Imaging (MRI).**

Procedure

I understand this is a process that uses a magnetic field and pulsing radio wave energy to provide pictures of organs and structures inside the body. The **benefit** is that in many cases MRI provides information that cannot be obtained from **alternative** methods of imaging such as an x-ray, ultrasound or CT scan.

I understand there are no known harmful effects from the strong magnetic field; however, the magnet may affect pacemakers, artificial limbs, and other medical devices which contain iron. Metal fragments, if any are embedded in eyes, can cause damage to the eyes. Iron pigments in tattoos or tattooed eyeliner can cause skin or eye irritation. If IV contrast is used, there are some risks which may occur rarely. I have reviewed the list on the back side and have informed the staff of all ferromagnetic particles in my body. I understand that I must take full responsibility for informing the MRI personnel of these metallic particles

I understand this test will be done **with** ☐ **without** ☐ contrast. **Contrast** refers to a solution taken by mouth or injected in to an intravenous line that causes the particular organ or tissue being studied to be seen more clearly. Contrast may help evaluate blood flow and detect some types of tumors, and locate areas of inflammation.

Risks and Complications of Contrast

Risks and complications of contrast, although very rare, could include such adverse reactions as:
Body as a Whole: Injection site symptoms, namely, pain, localized warmth, and burning sensation; substernal chest pain, back pain, fever, weakness, generalized coldness, generalized warmth, localized edema, tiredness, chest tightness, trembling, shivering, tension in extremities, regional lymphangitis, pelvic pain, and anaphylactoid reactions (characterized by cardiovascular, respiratory and cutaneous symptoms) rarely resulting in death.
Cardiovascular: Hypotension, hypertension, arrhythmia, tachycardia, migraine, syncope, vasodilation, pallor, non-specified ECG changes, angina pectoris, and death related to myocardial infarction or other undetermined causes, phlebitis, thrombophlebitis, deep vein thrombophlebitis, compartment syndrome requiring surgical intervention.
Digestive: Gastrointestinal distress, stomach pain, teeth pain, increased salivation, abdominal pain, vomiting, constipation, diarrhea.
Nervous System: Agitation, anxiety, thirst, anorexia, nystagmus, drowsiness, diplopia, stupor, convulsions (including grand mal), paresthesia.
Respiratory System: Throat irritation, rhinorrhea, sneezing, dyspnea, wheezing, laryngismus, cough, respiratory complaints.
Skin: Rash, sweating, pruritus, urticaria (hives), facial edema, erythema multiforme, epidermal necroysis, pustules.
Special Senses: Tinnitus, conjunctivitis, visual field defect, taste abnormality, dry mouth, lacrimation disorder (tearing), eye irritation, eye pain, ear pain.
Pregnancy: At this time there are no published risks related to pregnancy, however, long term effects are not yet known.
Miscellaneous: Nephrogenic Systemic Fibrosis has been reported in patients who have severe kidney disease.

Additionally, complications with intravenous placement can include tissue or vessel damage, hematoma, infection, bruising or allergic reaction.

I have spoken with my physician/designee about this test, and about the risks of not having it done. I have read this consent form, and have had the procedure explained to me. I hereby consent. I understand that medicine is not an exact science. I acknowledge that no guarantees or assurances have been made to me by anyone regarding the results, success, outcome of the procedure, and there is always the risk of serious complications or death.

I understand and read the English language or have had adequate interpretation or translation of this document. Any and all questions I had regarding this/these proposed procedure(s) have been answered to my satisfaction. **I hereby give my informed and voluntary consent.**

_____ _____
Signature of Patient or Legal Representative **Relationship to Patient**

_____ _____
Witness **Date/Time**

_____ _____
Reason if Unable to Sign **Signature of Interpreter** (if applicable)

CONSENT FOR MAGNETIC RESONANCE IMAGING 0314

PATIENT ID LABEL

Florida Hospital Memorial Medical Center
Daytona/Oceanside

HEIGHT_____ (feet & inches or cm) WEIGHT_____ (pounds or kg)

REASON FOR MRI _____

DRUG ALLERGIES_____

SURGERIES & APPROXIMATE DATES_____

MEDICAL HISTORY (CANCER, CHEMO, etc.)_____

PREVIOUS EXAMS (CT, MRI, US, etc.)_____

The following items can interfere with MR Imaging, and **some** may be hazardous to your safety.

Please circle the correct answer for each of the following:

Have you ever worked as a machinist, metal worker, or in any profession grinding metal?					Yes	No
Injury to eyes involving metal	Yes	No		Seizures	Yes	No
Cardiac Pacemaker	Yes	No		Eyelid spring or wire	Yes	No
Implanted Cardioverter Defibrillator (ICD)	Yes	No		Electronic implant or device	Yes	No
Metallic stent	Yes	No		Spinal cord stimulator	Yes	No
IVC or Greenfield filter	Yes	No		Internal electrodes or wires	Yes	No
Metallic coil	Yes	No		Insulin or other infusion pump	Yes	No
Aneurysm clips	Yes	No		Shunt (spinal or ventricular)	Yes	No
Shrapnel, buckshot or bullets	Yes	No		Medication patch (nitroglycerin, nicotine, etc.)	Yes	No
Metallic fragment or foreign body	Yes	No		IUD, diaphragm, pessary	Yes	No
Surgical staples, clips or sutures	Yes	No		Jewelry and/or body piercing	Yes	No
Tissue Expander	Yes	No		Tattoo and/or permanent makeup	Yes	No
Any type of prosthesis (eye, penile, etc.)	Yes	No		Dentures or partial plates	Yes	No
Artificial or prosthetic limb	Yes	No				
Cochlear or other ear implant	Yes	No		Claustrophobic	Yes	No
Hearing aid (to be removed before scan)	Yes	No				

FEMALE PATIENTS: Date of last menstrual cycle: _____ Are you experiencing late periods?____
Are you pregnant? _____ Are you currently breastfeeding?_____

Form completed by: (Circle One) Patient Caretaker Relative (relationship)_____

_____
Signature of clinical person obtaining information

Power injector used for this procedure? YES NO IV contrast given YES NO
Location of IV site _____ Time of injection _____ BUN_____
Type and amount used_____ Saline amount _____ Creat_____ GFR _____

Lot # _____ Tech signature _____ Date:_____

If you are completing this form prior to your date of service and have any questions, please call (386) 671-4756

CONSENT FOR MAGNETIC RESONANCE IMAGING 0314

PATIENT ID LABEL