

# ADVANCED MRI AND IMAGING

2821 US HWY 27 North • Sebring, FL 33870  
Phone: (863) 385-8000 • Fax: (863) 385-8002

## Diagnostic Study Registration Form (CT with IV contrast) ( Page 1 of 3)

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Sex: ☐ Male ☐ Female

HOME ADDRESS \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

PRIMARY CARE PHYSICIAN \_\_\_\_\_

Patient Home Ph \_\_\_\_\_ Patient Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

AREA TO BE EXAMINED / TYPE OF EXAMINATION: \_\_\_\_\_

DIAGNOSIS OR CLINICAL SUSPICION \_\_\_\_\_

Have you had any previous X-Rays, MRIs, CT's, DEXA or Ultrasounds? ☐ Yes ☐ No

If yes: What \_\_\_\_\_ When \_\_\_\_\_ Where \_\_\_\_\_

☐ Yes ☐ No Have you ever smoked? If yes for how long? \_\_\_\_\_ How many packs a day? \_\_\_\_\_ If you are an ex-smoker, how long ago did you quit? \_\_\_\_\_

H/o Cancer ☐ YES ☐ NO If YES What type \_\_\_\_\_ Where \_\_\_\_\_

Radiation therapy: ☐ Yes ☐ No Chemotherapy: ☐ Yes ☐ No

List recent surgeries: \_\_\_\_\_

### IV Contrast History:

Do you have any personal history of:

☐ Yes ☐ No Asthma and/or allergic respiratory disease  
☐ Yes ☐ No Lung disease  
☐ Yes ☐ No Myeloma ☐ Yes ☐ No Proteinuria \_\_\_\_\_  
☐ Yes ☐ No **Diabetes**

**If Diabetic**, do you take oral medication containing Metformin ☐ Yes ☐ No  
\_\_\_\_\_ Glucophage \_\_\_\_\_ Metaglip \_\_\_\_\_ Avandamet \_\_\_\_\_ Riomet \_\_\_\_\_ Fortamet \_\_\_\_\_ Glucovance

☐ Yes ☐ No Kidney disease ☐ Yes ☐ No Kidney surgery  
☐ Yes ☐ No Heart disease, CHF, and or high blood pressure  
☐ Yes ☐ No Liver disease? ☐ Yes ☐ No Liver transplant/pending liver transplant?  
☐ Yes ☐ No Seizure disorder? ☐ Yes ☐ No Thyroid disorder?  
☐ Yes ☐ No Contrast exam performed within the last 7 days?  
☐ Yes ☐ No Are you **pregnant**? Date of last menstrual period: \_\_\_\_\_  
☐ Yes ☐ No Are you currently **breast feeding**?

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List any drug / food allergies: \_\_\_\_\_

Have you ever had an allergic reaction to x-ray contrast (IODINE DYE) \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please explain: \_\_\_\_\_

## Patients with Diabetes

If you are taking Metformin (Glucophage, Glucovance, etc.) and having a contrast injection in X-ray or CT today, you will be asked to stop taking it for 48 hours post injection of contrast media. This does not apply to MRI contrast injections. Contact your primary physician prior to restarting your Metformin (Glucophage, Glucovance, etc.) to make sure your renal functions are okay.

I will stop my Metformin (Glucophage, Glucovance, etc.) and contact my physician before restarting it.  
\_\_\_\_\_(Initial Here)

## IV Contrast Consent

CT examinations often require the use of contrast materials to enhance the visibility of certain tissues or blood vessels. The contrast material may be given as something to drink before your exam, or injected intravenously during your exam. In rare cases, the contrast material may be need to be given in the form of an enema to help visualize the lower colon in the pelvis. The intravenous contrast material contains **IODINE** and some people may be allergic. We screen all of our patients for this prior to administering the intravenous contrast material. We use **non-ionic** contrast material which is proven to be more tolerable. Some reactions such as nausea, vomiting, skin rash, hives, or other more severe reactions can occur, but are very uncommon. With the safety of the new **non-ionic** contrast materials, adverse effects are very rare but can happen.

I have answered the questions on page 1 to the best of my knowledge and understand the information presented to me. I consent to the use of IV Contrast during my exam.

Patient, Parent or Guardian, Responsible Party Signature \_\_\_\_\_

Date \_\_\_\_\_ Time \_\_\_\_\_

## FOR TECHNOLOGIST ONLY

Technologist \_\_\_\_\_

Oral contrast given \_\_\_\_\_ Amount \_\_\_\_\_

IV contrast given: Contrast type \_\_\_\_\_ Amount \_\_\_\_\_ (CC)

Contrast allergy \_\_\_\_\_ Yes \_\_\_\_\_ No

Patient premedicated for exam \_\_\_\_\_ Yes \_\_\_\_\_ No

Discharge instructions given for Metformin: \_\_\_\_\_ Yes \_\_\_\_\_ No

Discharge instructions given for nursing mothers \_\_\_\_\_ Yes \_\_\_\_\_ No

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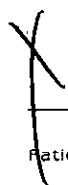
By signing this form, you are granting consent to Advanced MRI and Imaging to use and disclose your protected health information for the purpose of treatment ,payment, and health care operations as well as any ordered testing or imaging.

Our notice of privacy practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our notice of privacy practices before you sign this consent.

Our notice of privacy practices is subject to change. If we change our notice , you may obtain a copy of the revised notice from our office.

You have the right to request us to restrict how we use and disclose your protected health information for the purpose of treatment, payment , or health care operations. We are not required by law to grant your request. However , if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing , except to the extent we already have used or disclosed your protected health information in reliance on your original consent.

  
\_\_\_\_\_  
Patient Name ( Please Sign )

\_\_\_\_\_  
(Date)

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## **AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I authorize the physician/staff of Advanced MRI and Imaging to send artificial, prerecorded, or automated calls and text messages and to release/leave medical information, with the following (please check applicable):

\_\_\_\_\_ Spouse

\_\_\_\_\_ Significant other

\_\_\_\_\_ Family Member (name: \_\_\_\_\_)

\_\_\_\_\_ Caregiver

\_\_\_\_\_ Answering Machine

\_\_\_\_\_ Send artificial, prerecorded, or automated calls and text messages.

I understand and acknowledge that should I need to change how I receive my medical information or messages that it will be necessary to notify my provider/office to those changes.

 \_\_\_\_\_  
Signature of Patient (of parent/guardian or minor)

\_\_\_\_\_  
Date

### **ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

#### **FOR OFFICE USE ONLY**

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Advance MRI & Imaging is committed to the health and safety of all our patients, visitors and team members. We are conducting screening for COVID-19. If you answer yes to any of the questions below, you will be given further instructions.

We now require all patients to be wearing a mask at all times during your visit to the center.

1. Do you currently have a cough, fever, shortness of breath or difficulty breathing? **YES / NO**
2. Have you travelled outside highlands county within the past 14 days? **YES / NO**
3. If yes where?
4. Have you had close contact with someone with known or suspected COVID-19 in the last 14 days? **YES / NO**
5. Have you been tested for COVID-19 within the past 14 days? **YES / NO**  
If YES: When \_\_\_\_\_ What were the results? \_\_\_\_\_

Patient signature