ADVANCED MRI AND IMAGING

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

Diagnostic Study Registration Form (MRI with contrast)

Patient Name _____Date_____

Date of Birth _____Age _____Weight _____Height_____Sex: ___Male _____Female

HOME ADDRESS _____

MAILING ADDRESS_____

PRIMARY CARE PHYSICIAN_____

HOME PHONE _____ CELL PHONE _____BUSINESS PHONE_____

SOCIAL SECURITY NUMBER _____

Have you had any previous X-Rays, MRIs, CTs, DEXA or Ultrasounds? _____ Yes _____No

If yes: What _____When _____Where_____

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? _____ Cancer _____Yes _____No

If yes: What type _____Body Part _____

Radiation therapy: _____Yes _____No Chemotherapy: _____Yes___ No____

_____Yes _____No Are you **pregnant**? Date of last menstrual period:_____ ____

_____Yes _____No Are you currently **breast feeding**?

FOR PATIENTS GETTING MRI WITH CONTRAST :
Do you have any personal history of:

Diabetes: _____Yes _____No Kidney disease: ____Yes ___No Multiple Myeloma ___Yes __No__

Kidney surgery: ____Yes _____No Heart disease, CHF, and or high blood pressure ____Yes _____ No

Gad Contrast allergy_____Yes _____No Any other allergy_____Yes_____No

FOR TECHNOLOGIST ONLY
IV contrast given: Contrast type
_____Amount_____(CCs)IVsite_____ Patient premedicated _____Yes_____No_____

BUN _____CR_____GFR _____ Date_____

Contrast reaction: _____Yes ____No Discharge instructions given for contrast reaction: ___Yes __NO

Tech initial _____

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ATTENTION MR PATIENTS AND ACCOMPANYING FAMILY MEMBERS

The MR room contains a very strong magnet. Before you are allowed to enter, we must know if you have any metal in your body. **MRI cannot be performed if Yes is answered to the following SIX Questions. Please read completely and check those that apply.**

PACEMAKER, wires or defibrillator	Yes / No
Brain/aneurysm clip	Yes / No
Tissue expander for future implants e.g Breast.	Yes / No
Retained Small Bowel Endoscopy Capsule	Yes / No
Triggerfish contact lens	Yes / No
Linx reflux management devise for GERD	Yes / No
Penileprosthesis(Duraphase and Omniphase are CI)	Yes / No

Please Indicate If You Have Any Of The Following Items In Your Body:

Ear implant or **HEARING AID** (must be removed prior to MRI)	Yes / No
Infusion pump, or medication pump of any kind	Yes / No
Do you have claustrophobia (fear of enclosed spaces)?	Yes / No
Eye implant or eyelid implant	Yes / No
Electrical stimulator for nerves or bone, spinal cord	Yes / No
Magnetic implant (anywhere in the body)	Yes / No
Skin patch for medication	Yes / No
Coil, filter, or wire in a blood vessel	Yes / No
Artificial limb or joint	Yes / No
Eyelid tattooMagnetic lashes, body piercings	Yes / No
Implanted catheter or tube	Yes / No
Artificial heart valve	Yes / No
Shunt spinal or intraventricular	Yes / No
False teeth, retainers, or magnetic braces, dentures	Yes / No
Surgical clips, staples, wires, mesh, or sutures	Yes / No
Recent surgery (in the last **6-8 weeks**)	Yes / No
Intrauterine device (IUD)	Yes / No
Orthopaedic hardware (plates, screws, pins, rods, wires)	Yes / No
Bullets, BBs or pellets	Yes / No
Metal shrapnel or fragments	Yes / No
Have you ever been a machinist, welder or metal worker?	Yes / No
Have you ever been hit in the face or eye with a piece of metal (including shavings, slivers, bullets or BBs)?	Yes / No
Have you ever had a piece of metal removed from your eye?	Yes / No

The normal function of the MR unit generates electrical currents which may create a sensation of warmth, either in the sides of the imaging unit or in the surrounding coil. If you experience any focal warmth that leads to discomfort, please notify the technologist immediately.

I attest that the answers I have provided to questions on this form are correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form. I understand that it is my responsibility to inform the office of any metal and/or any devices that may be in my body, be failing to do so may cause serious bodily injury or be life-threatening. I agree that should I have any metal in my body and after consultation with a physician, elected to proceed with the MRI, I agree to release advanced MRI and Imaging from any and All liability for any injury,

Patient or Legal Representative Signature: _____ Date:_____

Tech signature _____

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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.

X _____

Patient Name (Please Sign)

_____

(Date)

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CONSENT FOR MRI CONTRAST MATERIAL INJECTION

Your doctor has scheduled you for an MRI examination that requires an injection of contrast into your bloodstream. As you know, an MRI is a picture of what is inside you. The agent, called gadolinium (also termed contrast media, contrast material or "MRI dye"), shows up bright on MRI scan images and helps the radiologist interpret the MRI scans.
The contrast media is given through a small needle (catheter) placed into a vein, usually on the inside of the elbow or on the back of your hand. Normally, contrast media is considered quite safe; however, any injection carries a slight risk of harm including injury to the nerve, artery, or vein, infection or reaction to the material being injected. Occasionally, a patient will have a mild reaction to the contrast agent and develop sneezing and/or hives. Please note that serious reactions including severe allergic response, shock, and death are extraordinarily uncommon with this contrast agent.
If you have any questions, please ask the MRI technologist or the attending radiologist.

I have read the above information and have had my questions answered. I have reviewed the information regarding the MRI contrast Gadavist , provided to me as a separate information sheet.

Signed_____Date_____

Print Name_____Witness_____

Medication Guide

GADAVIST
(gad-a-vist)
(gadobutrol)
Injection for intravenous use

What is Gadavist?

- Gadavist is a prescription medicine called a gadolinium-based contrast agent (GBCA). Gadavist, like other GBCAs, is injected into your vein and used with a magnetic resonance imaging (MRI) scanner.
- An MRI exam with a GBCA, including Gadavist, helps your doctor to see problems better than an MRI exam without a GBCA.
- Your doctor has reviewed your medical records and has determined that you would benefit from using a GBCA with your MRI exam.

What is the most important information I should know about Gadavist?

- Gadavist contains a metal called gadolinium. Small amounts of gadolinium can stay in your body including the brain, bones, skin and other parts of your body for a long time (several months to years).
- It is not known how gadolinium may affect you, but so far, studies have not found harmful effects in patients with normal kidneys
- Rarely, patients have reported pains, tiredness, and skin, muscle or bone ailments for a long time, but these symptoms have not been directly linked to gadolinium.
- There are different GBCAs that can be used for your MRI exam. The amount of gadolinium that stays in the body is different for different gadolinium medicines. Gadolinium stays in the body more after Omniscan or Optimark than after Eovist, Magnevist, or MultiHance. Gadolinium stays in the body the least after Dotarem, Gadavist, or ProHance.
- People who get many doses of gadolinium medicines, women who are pregnant and young children may be at increased risk from gadolinium staying in the body.
- Some people with kidney problems who get gadolinium medicines can develop a condition with severe thickening of the skin, muscles and other organs in the body (nephrogenic systemic fibrosis). Your healthcare provider should screen you to see how well your kidneys are working before you receive Gadavist.

Do not receive Gadavist if you have had a severe allergic reaction to Gadavist.

Before receiving Gadavist, tell your healthcare provider about all your medical conditions, including if you:

- have had any MRI procedures in the past where you received a GBCA. Your healthcare provider may ask you for more information including the dates of these MRI procedures.
- are pregnant or plan to become pregnant. It is not known if Gadavist can harm your unborn baby. Talk to your healthcare provider about the possible risks to an unborn baby if a GBCA such as Gadavist is received during pregnancy.
- have kidney problems, diabetes, or high blood pressure
- have had an allergic reaction to dyes (contrast agents) including GBCAs

What are the possible side effects of Gadavist?

- **See "What is the most important information I should know about Gadavist?"**
- **Allergic reactions. Gadavist can cause allergic reactions that can sometimes be serious. Your healthcare provider will monitor you closely for symptoms of an allergic reaction.**

The most common side effects of Gadavist include: headache, nausea, and dizziness.
These are not all the possible side effects of Gadavist.

Call your doctor for medical advice about side effects. You may report side effects to FDA at 1-800-FDA-1088.

General information about the safe and effective use of Gadavist.

Medicines are sometimes prescribed for purposes other than those listed in a Medication Guide. You can ask your healthcare provider for information about Gadavist that is written for health professionals.

What are the ingredients in Gadavist?

Active ingredient: gadobutrol

Inactive ingredients: calcobutrol sodium, trometamol, hydrochloric acid (for pH adjustment) and water for injection

Manufactured for Bayer HealthCare Pharmaceuticals Inc.

Manufactured in Germany

For more information, go to www.gadavist.com or call 1-888-842-2937.

This Medication Guide has been approved by the U.S. Food and Drug Administration. Rev. 4/2018

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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 test 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.

X _____

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 difficulity 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-1`9 within the past 14 days? **YES / NO**

   If YES: When_____ What were the results?_____

Patient signature