GUAM RADIOLOGY CONSULTANTS

Guam Medical Plaza, Suite 210 663 Governor Carlos Camacho Road, Tamuning, Guam 96913
Tel: (671) 649-1001 Fax: (671) 649-1002

Patient Name: ____________________________________ Date of Birth: ____________________________

INFORMED CONSENT FOR MRI EXAM WITH AND/OR WITHOUT CONTRAST INJECTION

CONSENT FOR IMAGING PROCEDURE:

My healthcare provider believes it beneficial for me to undergo a diagnostic imaging procedure known as magnetic resonance imaging (MRI) to obtain information that may aid in diagnosing and treating my medical condition. It has been explained to me that MRI does not use x-rays or radiation. Instead, a magnetic field and radio waves will be used to create an image of internal body structures. MRI is a painless procedure that only requires that I lie quietly on a padded table that will gently glide me into the magnet while the scanner is performing my scan, I will hear loud banging and thumping sounds. In some cases, a contrast agent may be injected into my veins in order to give a clearer image of the area being examined. The MRI study may be conducted without the injection of the contrast I will inform the technologist if I wish to change my mind and refuse the contrast injection.

Because of the magnetic field and radio frequencies, people with a heart pacemaker, ICD, brain aneurysm clips and some implanted metallic or electrical devices should not have an MRI.

I have thoroughly read and completed the MRI safety screening form and will inform the technologist if I have any questions or concerns regarding metal that may be in or on my body.

I will inform the technologist if I think I am pregnant or may be pregnant

POTENTIAL RISKS:

Anytime an injection is given there is the potential for bruising or swelling at the injection site. Occasionally, minor allergic reactions occur in the form of itching, sneezing, hives, swelling of the eyes, wheezing or nausea. The symptoms may require treatment with medication that is on hand at Guam Radiology Consultants. Very rarely, a more serious reaction can occur. The radiologist will evaluate the situation and determine if additional medical treatment is necessary. Even though it is extremely rare, medical statistics indicate that a fatality could potentially occur from the injection of contrast. If I have sickle cell anemia, a kidney disorder, or if I am pregnant or breast-feeding I will not sign this form unless I have informed a radiologist at this facility and have discussed it with the radiologist

The benefit of this exam is to assist my healthcare provider in making a diagnosis and or making the right treatment choices. There may be other imaging alternatives, however, my healthcare provider believes that for me at this time, MRI is the best diagnostic test.

By my signature below, I hereby certify that I have fully read this consent, had it explained to me or have had it read to me. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, the procedure/s to be used, and the risks and hazards involved.

I, the undersigned, being either the patient named above or legally authorized of the patient named above, do hereby consent to the performance of an MRI at Guam Radiology Consultants on the terms and conditions more fully set out above. I understand the procedure to my satisfaction and have had an opportunity to ask questions regarding the procedure. Any questions I have asked, have been answered in language I feel I understand. I feel adequately informed about the procedure being used and I do not feel rushed or pressured to make the decision whether not to undergo the procedure.

I understand this consent and have sufficient information to give this informed consent.

____________________________________ ____________________________________
PATIENT/PARENT/LEGALGUARDIAN SIGNATURE WITNESS SIGNATURE

____________________________________ ____________________________________
DATE/TIME DATE/TIME

__________________ __________________

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Patient Name: **DOB:**

PATIENT HISTORY AND SAFETY SCREENING FOR MRI EXAMINATIONS

Please complete this safety form prior to your exam. It is important that you read and complete the entire form.

1. **Why did your doctor refer you to have an MRI? (i.e. injury, pain, lump, mass, etc.)**

   ____

   If this is exam is because you sustained an injury, write down how you got injured. *Please be specific.*

   ____

2. When is your follow-up appointment with your doctor? ☐No ☐ Yes. If yes, when? Date: ______________

3. Besides the referring provider, is there any other provider that you would like us to send your report to?

   ☐ No ☐ Yes, If yes, who? ____________________ Name of Facility: ____________________

4. Would you like us to send your report to your primary care provider?

   ☐ No ☐ Yes, If yes, who? ____________________ Name of Facility: ____________________

5. **Have you ever had chemotherapy?** ☐No ☐ Yes. If yes, when? Date: ______________

6. **Have you ever had radiation therapy?** ☐No ☐ Yes. If yes, when? Date: ______________

7. **Have you ever had surgery?**

   (Including any operation or procedure including arthroscopy, endoscopy, etc.) ☐No ☐ Yes
   If **YES**, please list the date(s) and type(s) of surgery:

Date:		Surgery:		Facility:	
Date:		Surgery:		Facility:	
Date:		Surgery:		Facility:	
Date:		Surgery:		Facility:	

8. **Have you had prior imaging studies related to this MRI such as a prior MRI, CAT Scan, Ultrasound, Nuclear Medicine, or regular X-Ray Exam:** ☐No ☐ Yes If YES, please list:

Date:		Exam:		Facility:	
Date:		Exam:		Facility:	
Date:		Exam:		Facility:	
Date:		Exam:		Facility:	

9. **Have you experienced any problem related to a previous MRI examination?**
   ☐No ☐ Yes, please describe: ______________________________

10. **Have you had an injury to the eye involving a metallic object/fragment (e.g. metallic slivers, shavings)?**
    ☐No ☐ Yes, please describe: ______________________________

11. **Have you ever been injured by a metallic object or a metallic foreign body (e.g. BB, bullet, shrapnel)?**
    ☐No ☐ Yes, please describe: ______________________________

12. **Have you ever worked as a welder, machinist or in job that could expose you to loose metal fragments?**
    ☐No ☐ Yes, when: ______________________________

13. **Have you ever done any welding, machining, metal working or metal grinding?**
    ☐No ☐ Yes, when: ______________________________

 MRI TECH: ____________ **MRI TECH ASST.** ____________

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Patient Name: **DOB:**

MEDICAL HISTORY

1. On a scale of 1 – 10, ten being the worst, what is your pain level today?

   ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

2. Have you ever had a reaction to contrast dye used for MRI, CT, or X-Ray examination? ☐No ☐ Yes
3. Do you have
   a. Anemia or any disease that affects your blood? ☐No ☐ Yes
   b. ESRD or kidney disease? ☐No ☐ Yes
   c. Asthma? ☐No ☐ Yes
   d. Lung Disease? ☐No ☐ Yes
   e. Diabetes? ☐No ☐ Yes
   f. Hypertension? ☐No ☐ Yes
   g. High Cholesterol? ☐No ☐ Yes
   h. Seizure? ☐No ☐ Yes
   i. Motion Disorder? ☐No ☐ Yes
   j. Spinal Fusion? ☐No ☐ Yes

ALLERGY LISTING

KNOWN PATIENT ALLERGIES:

Do you have any allergies to medication or food that is not listed above?

☐NO ☐YES: ____.

FOR FEMALE PATIENTS ONLY

1. Are you post-menopausal? ☐ Yes ☐ No, If no: Date of last menstrual period: __________.
2. Are you pregnant or experiencing a late menstrual period?

   ☐ Yes ☐ No, please **WRITE** the words "**I AM NOT PREGNANT**" in the grey area below:

3. Are you taking birth control pills or any contraceptives? ☐ No ☐ Yes, *please list on Medication List*
4. Are you taking any type of fertility or hormonal medication or having fertility treatments?

   ☐ No ☐ Yes, If yes, please describe: ______________________

5. Are you currently breastfeeding? ☐ No ☐ Yes

MRI TECH: .... **MRI TECH ASST.** ....

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Patient Name: **DOB:**

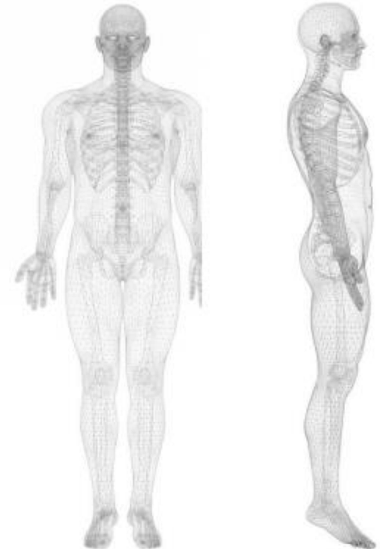
Please indicate if you have any of the following:

SURIGICALLY IMPLANTED MEDICAL DEVICES		
Aneurysm Clip	☐ YES	☐ NO
Cardiac pacemaker	☐ YES	☐ NO
Implanted cardioverter / defibrillator (ICD)	☐ YES	☐ NO
Aortic clips	☐ YES	☐ NO
Carotid artery vascular clamp	☐ YES	☐ NO
Vascular access port or catheters	☐ YES	☐ NO
Implant/device of any type Magnetically activated	☐ YES	☐ NO
Implant/device Neuro/spinal cord stimulator system	☐ YES	☐ NO
Internal electrodes or wires	☐ YES	☐ NO
Bone growth or bone fusion stimulator	☐ YES	☐ NO
Cochlear, otologic, or other ear implant	☐ YES	☐ NO
Ear tubes	☐ YES	☐ NO
Implanted drug infusion device	☐ YES	☐ NO
Insulin or other medicine infusion device	☐ YES	☐ NO
Any type of prosthesis (eye, penile, etc.)	☐ YES	☐ NO
Electrodes (on body, head, or brain)	☐ YES	☐ NO
Artificial heart valve or heart stent	☐ YES	☐ NO
Eyelid spring or wire	☐ YES	☐ NO
Metallic stent, filter, or coiled any type	☐ YES	☐ NO
Shunt (spinal, intraventricular, or other)	☐ YES	☐ NO
Artificial or prosthetic limb	☐ YES	☐ NO
Radiation seeds or implants	☐ YES	☐ NO
Wire mesh or patch implant (i.e. Hernia Repair)	☐ YES	☐ NO
Tissue expander (e.g., Breast)	☐ YES	☐ NO
Surgical staples, clips, or metallic sutures	☐ YES	☐ NO
Joint replacement (hip, knee, etc.)	☐ YES	☐ NO
Bone or joint and, screw, nail, wire, plate, etc.	☐ YES	☐ NO
Swan-Ganz or thermodilution catheter	☐ YES	☐ NO
IUD, contraceptive diaphragm, or pessary	☐ YES	☐ NO
REMOVABLE DEVICES		
Hearing aid	☐ YES	☐ NO
Dentures or partial plates or Braces or Metal Retainers	☐ YES	☐ NO
Medication patch (Nicotine, Nitroglycerin)	☐ YES	☐ NO
Tattoo or permanent makeup	☐ YES	☐ NO
Colored contact lenses	☐ YES	☐ NO
A body piercing jewelry (any type)	☐ YES	☐ NO
Wig, Hair implants	☐ YES	☐ NO
Hair Accessories	☐ YES	☐ NO
Metal-containing clothing material	☐ YES	☐ NO
Magnetic cosmetics and hair care (i.e. eyelashes, magnetic nail polish, eye liner)	☐ YES	☐ NO
Fitness tracker/bio-monitor	☐ YES	☐ NO
OTHER:	☐ YES	☐ NO

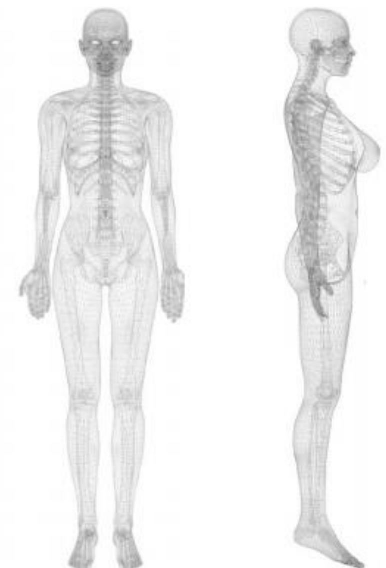
MR Hazard Checklist

Please mark the location of any implant, device or metallic foreign body inside your body or site of surgical operation.

Male:



Female:



Revised 05-18-2023

MRI TECH: ____________ **MRI TECH ASST.** ____________

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INSTRUCTIONS FOR PATIENTS

1. **The MRI machine is very loud. You will be provided hearing protection during your scan.** You have the choice of ear plugs or headphones with your choice of music. You are strongly urged to use the Earplugs or headphones provided to you during your MR examination, since some patients find the noise levels unacceptable, and the noise levels may affect your hearing if these provided hearing protection devices are not utilized.
2. Some clothing may contain metal even when not apparent, you must remove all clothing and worn/removable items from your body. **MR Safe clothing will be provided to you to wear during your MRI scan.** This is being done to help ensure your safety during the examination.
3. Remove all jewelry, watches, cell phones, fitness devices and body piercings
4. Removal all hair pins, bobby pins, barrettes, clips, etc.
5. Remove all dentures, false teeth, partial dental plates
6. Remove eyeglasses and hearing aids
7. Remove all cards with magnetic strips (e.g. credit cards, bank cards, etc.)
8. Remove all metal belongings such as money clips, coins, pencils, pens, pocketknives, nail clippers and tools
9. **If you are unable to remove any of the above items, please notify the technologist.**
10. **If your exam has been ordered with contrast, an IV catheter will be inserted in your arm by a nurse, technologist, or other trained MRI personnel.**

I attest that the above information included in Guam Radiology Consultant's "PATIENT HISTORY AND SAFETY SCREENING FOR MRI EXAMINATIONS" is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MR procedure that I am about to undergo.

Patient Signature or (if patient is a minor, parent, or legal guardian):

______________________	______________________
Signature	Date

If the signature is not from the patient:

______________________	______________________
Print name	Relationship to patient

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI procedure. Do not enter the MR system room if you have any questions or concerns, including questions regarding an implant or other medical device. You should consult the MRI Technologist or Radiologist with any concerns BEFORE entering the MR system room.
The MR system magnet is ALWAYS on.

MRI TECH: ______ **MRI TECH ASST.** ______

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FROM: MRI DEPARTMENT
SUBJECT: REQUEST FOR MEDICAL RECORDS

MESSAGE:

Please prepare previous reports and images for patient:

__________________________________ ____________________
Full Name of Patient *Date of Birth*

Please call 647-3667 when the CD is ready to be picked up. Please fax prior reports to our main fax number (671) 649-1002.

REQUEST FOR MEDICAL RECORDS

I, the undersigned, hereby authorize:

- ☐ **GUAM REGIONAL MEDICAL CITY**
- ☐ **GUAM MEMORIAL HOSPITAL**
- ☐ **FHP HEALTH CENTER**
- ☐ **MDX IMAGING**
- ☐ **SDA RADIOLOGY**
- ☐ **IHP CLINIC**
- ☐ **AMERICAN MEDICAL CENTER**
- ☐ **GUAM SURGICAL CENTER**
- ☐ **OTHER: ____________________________**

to release my radiology exams and reports (BMD, CT scan, DXA, Ultrasound, MRI, X-Ray reports, etc.) or any progress notes and/or pathology reports to Guam Radiology Consultants for the course of my examination or treatment. A photocopy of a faxed copy of this form will serve as an original. This form, unless directed by me to be invalidated, shall remain effective for twenty-four (24) months from the date of my signature.

____
Patient Signature

Today's Date:

____
If patient is a minor, please print parent/legal guardian name

Relationship to Patient: ☐ Parent ☐ Legal Guardian