

Introduction

The scan your doctor has asked us to perform may require the injection of contrast medium. This is a medical dye called Gadolinium used to help delineate various structures in the body. The dye is different to that used for X-ray or CT.

If you have a history of poor renal function or have ever been on dialysis, please inform the staff member prior to commencing the scan

Risks and side effects

As with most drugs, side effects and adverse reactions are possible. These may occur during or after the procedure.

Side effects associated with the procedure may include a brief metallic taste or smell. Occasionally side effects such as nausea or a rash (hives) may occur. More severe allergic reactions may result in shortness of breath and facial swelling. It is extremely rare for reactions to be life threatening. Patients with severe Renal (kidney) impairment have a very small risk of developing a specific irreversible disorder called Nephrogenic Systemic Fibrosis (NSF).

Please ask the MRI technologist questions about anything on this form that you do not understand.

To further reduce the risk of an adverse reaction it is important that you answer the following questions. Please **circle** your response and answer all questions below.

Have you previously had an injection of MRI contrast? YES NO N/A

If YES, did you have an adverse reaction to the MRI Contrast? YES NO N/A

Do you have Poor Kidney Function? YES NO N/A

If YES, what date was it last checked? _____

For some Pelvic or Abdominal studies you may also be administered a drug called Buscopan. This is an antispasmodic medication designed to reduce peristalsis of the bowel for a short duration. This enables much clearer imaging of the surrounding anatomy.

Do you have an eye pressure issue called Glaucoma? YES NO N/A

If YES, has it been treated? YES NO N/A

Do you have any heart conditions/arrhythmias? YES NO N/A

Do you have asthma? YES NO N/A

I have read the information provided regarding my procedure. I understand the information and have had the opportunity to ask questions about what is going to happen, the reasons for the procedure being performed, and the associated risks. I agree to have the procedure performed. I further agree to the results of my scan being shared for research and referral purposes.

Patient Name _____

Patient Signature _____ Date _____
(or signature of legal guardian)

Signature of MIT / Radiologist _____

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Anticoagulants Yes No Diabetic Yes No Allergies Yes No Driver Yes No

Patient Id Checklist
Name Confirmed Dob Confirmed Gender Confirmed Address Confirmed

Procedure Checklist
Type Confirmed Side Confirmed Consent Confirmed Time Out