MRI Contrast Screening Form

Today's Date_______________

Name______________________________________ DOB____________ Age______ Wt______

Have you had Gadolinium/IV contrast before? NO YES (If yes detail below)

Type of MRI______________________ Date________________Location___________________

Have you ever had a reaction to Gadolinium? NO YES (If yes detail below)

Details____

Are you allergic to anything? NO YES (If yes detail below)

Details____

Females:

Any chance of pregnancy? YES NO Last period___________________

Breastfeeding? YES NO

<u>Please Check Any That Apply:</u>

- ☐ Kidney problems
- ☐ Dialysis
- ☐ Diabetes
- ☐ Cancer_____________________
- ☐ Liver disease
- ☐ Heart disease
- ☐ Lung Disease

MRI Patients:

I understand that Gadolinium contrast will be injected. Few patients receiving this may develop headache and nausea. Inflammation at the injection site can occur. Severe reactions are extremely rare.

Patient Signature______________________________________ Date___________________

Labs: BUN__________________ Creatinine______________________ GFR_______________

Contrast: Type_________________ Amount_________________________ Site_______________

Tech Comments____

Reviewed by Tech (Signature)___________________________________ Date ______________

Translator _____________________________________ Translator Signature_____________________________