



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

2. **Do you have a follow-up appointment SCHEDULED with your Specialist or Primary Care Provider after today's MRI appointment?**  No  Yes. If yes, when? Date: \_\_\_\_\_.

3. Are there any other provider that you would like us to send your report to?  
 No  Yes, If yes, who? \_\_\_\_\_ Name of Facility: \_\_\_\_\_

4. **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: _____

5. **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: _____

6. **Have you experienced any problem related to a previous MRI examination?**  
 No  Yes, please describe: \_\_\_\_\_

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

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

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

10. **Have you ever done any welding, machining, metal working or metal grinding?**  
 No  Yes, when: \_\_\_\_\_



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## MEDICAL HISTORY

1. Do you have anemia or any disease that affects your blood, history of renal (kidney) disease, seizures or a motion disorder?  No  Yes, please describe \_\_\_\_\_.
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 history of Asthma?  No  Yes
4. Do you have a history of Lung Disease?  No  Yes

## ALLERGY LISTING

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

NO  YES: \_\_\_\_\_.

## COVID HEALTH SCREENING

Are you currently experiencing the any of the following flu-like symptoms?  YES  NO

- Which:  Cough  Body Aches  Chills  
 Fever  Sore Throat  Shortness of Breath  Loss of Smell or Taste

## 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



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## MEDICATION LIST

**LIST ALL MEDICINES YOU ARE CURRENTLY TAKING:** Prescription and over-the-counter medications (example: aspirin, antacids) Include medications taken as needed (example: nitroglycerin).

<b>MEDICATION LIST</b>			
<i>Name of Medication</i>	<i>Reason</i>	<i>Name of Medication</i>	<i>Reason</i>

## PAIN INDICATION

1. On a Scale of 0 to 10 (ten being the greatest), how much pain are you currently in?

0  1  2  3  4  5

6  7  8  9  10

2. Are you currently taking any form of medication to address the pain (such as Percocet, Vicodin, Oxycodone, etc.)?

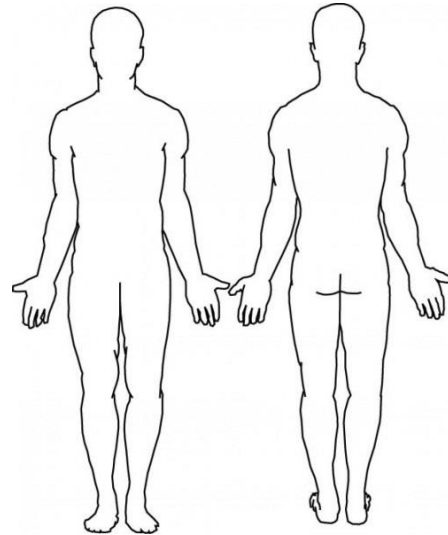
No  Yes, what:

3. Does the pain prevent you from participating in daily activities such as work or sleep?  No  Yes

4. Are you currently seeing/scheduled to be seen for physical therapy or neurosurgery?

No  Yes, If so, when: \_\_\_\_\_

5. Using the diagram below, **circle and label** the specific area where you are feeling pain, numbness, etc. **IF NONE, please indicate "None"**.



**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.**



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Please indicate if you have any of the following:

### SURIGICALLY IMPLANTED MEDICAL DEVICES

Aneurysm Clip	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cardiac pacemaker	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Implanted cardioverter / defibrillator (ICD)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Aortic clips	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Carotid artery vascular clamp	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Vascular access port or catheters	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Implant/device of any type Magnetically activated	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Implant/device Neuro/spinal cord stimulator system	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Internal electrodes or wires	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Bone growth or bone fusion stimulator	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Cochlear, otologic, or other ear implant	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Ear tubes	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Implanted drug infusion device	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Insulin or other medicine infusion device	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any type of prosthesis (eye, penile, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Electrodes (on body, head, or brain)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Artificial heart valve or heart stent	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Eyelid spring or wire	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Metallic stent, filter, or coiled any type	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Shunt (spinal, intraventricular, or other)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Artificial or prosthetic limb	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Radiation seeds or implants	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Wire mesh or patch implant (i.e. Hernia Repair)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Tissue expander (e.g., Breast)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Surgical staples, clips, or metallic sutures	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Joint replacement (hip, knee, etc.)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Bone or joint and, screw, nail, wire, plate, etc.	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Swan-Ganz or thermodilution catheter	<input type="checkbox"/> YES	<input type="checkbox"/> NO
IUD, contraceptive diaphragm, or pessary	<input type="checkbox"/> YES	<input type="checkbox"/> NO

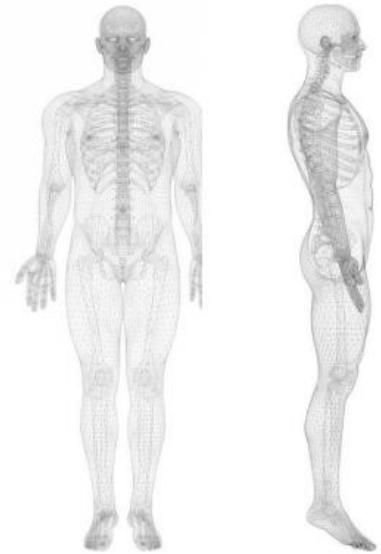
### REMOVABLE DEVICES

Hearing aid	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Dentures or partial plates or Braces or Metal Retainers	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Medication patch (Nicotine, Nitroglycerin)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Tattoo or permanent makeup	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Colored contact lenses	<input type="checkbox"/> YES	<input type="checkbox"/> NO
A body piercing jewelry (any type)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Wig, Hair implants	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Hair Accessories	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Metal-containing clothing material	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Magnetic cosmetics and hair care (i.e. eyelashes, magnetic nail polish, eye liner)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Fitness tracker/bio-monitor	<input type="checkbox"/> YES	<input type="checkbox"/> NO
<b>OTHER:</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO

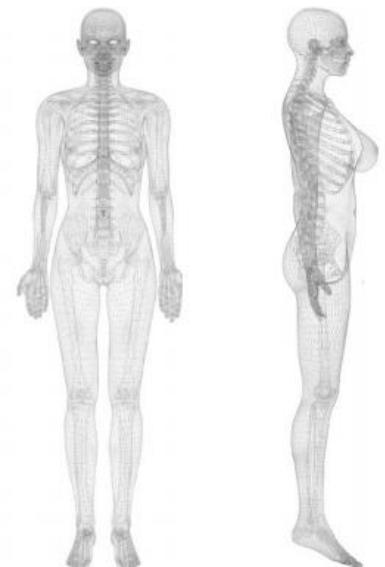
### MR Hazard Checklist

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

Male:



Female:





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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 and body piercings (e.g. necklaces, pins, rings)
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 watches, cell phones, fitness devices
8. Remove all cards with magnetic strips (e.g. credit cards, bank cards, etc.)
9. Remove all metal belongings such as money clips, coins, pencils, pens, pocketknives, nail clippers and tools
10. **If you are unable to remove any of the above items, please notify the technologist.**
11. **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