



Date: \_\_\_\_\_

Name: \_\_\_\_\_

Sex:  M  F

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Birth Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**\* DO NOT ENTER THE MRI ROOM WITHOUT CLEARANCE FROM THE TECHNOLOGIST. \***

Some of the following items may be hazardous to your safety and can interfere with the MRI exam.

**Do you have?**

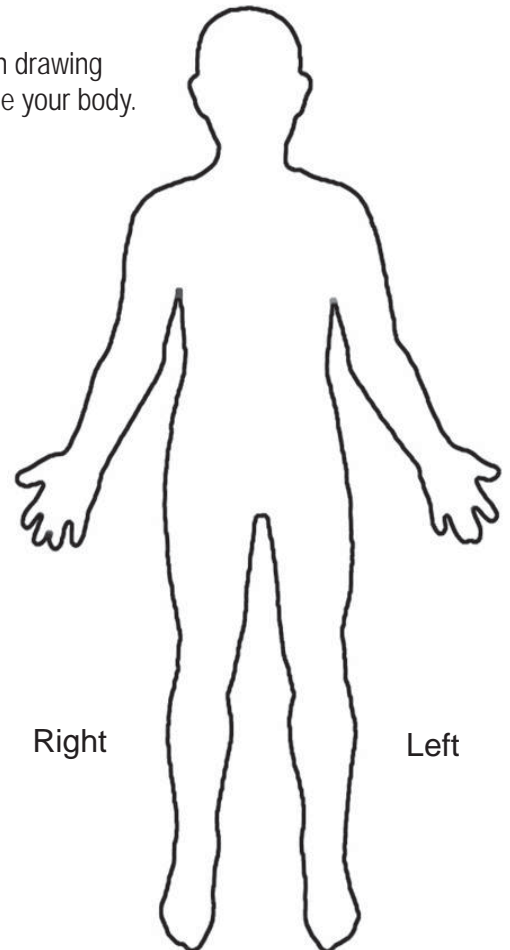
Yes No

- Cardiac Pacemaker
- Previous cardiac pacemaker removed
- Implanted cardiac defibrillator
- Carotid artery vascular clamp
- Aneurysm clip(s) in Brain
- Implanted drug infusion device
- Bone growth/fusion stimulator
- Neurostimulator (TENS-Unit)
- Any type of Biostimulator
- Cochlear, otologic, or ear implant
- Hearing aid (Remove before MRI)
- Transdermal Medication Patch: If yes, type: \_\_\_\_\_
- Any type of implanted item: \_\_\_\_\_
- Any type of prosthesis (Heart, Valve, Eye, Penile, etc...)
- Artificial limb or joint
- Electrodes (on body, head, or brain)
- Intravascular stents, filters, or coils (ie Gianturke, Greenfield)
- Shunt (spinal or intraventricular)
- Vascular access port and/or catheter
- Swan-Ganz catheter
- Any implant held in place by a magnet
- IUD or diaphragm
- Any metal fragments – Shrapnel or Bullet
- Internal pacing wires
- Aortic clip
- Metal or wire mesh implants
- Wire sutures or surgical staples
- Harrington rods (spine) or metal rods on bones
- Joint replacement: \_\_\_\_\_

Yes No

- Bone/Joint pin, screw, nail, wire, plate
- Tattooed makeup (eyeliner, lips, etc...)
- Body piercing(s)
- Dentures or Dental Braces
- Removable dental item (Remove before MRI)
- Claustrophobia, Anxiety, Motion Disorder

Please mark on drawing any metal inside your body.



**- Please turn over to complete form. -**



Patient Name: \_\_\_\_\_

1. Have you ever had an injury to the eye involving a metallic object (e.g.metallic slivers, shavings, foreign body)?  Yes  No

If yes, please describe: \_\_\_\_\_

\*2. Are you pregnant or experiencing a late menstrual period?  Yes  No

Date of last period? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\*3. Are you breast feeding?  Yes  No

4. Do you have drug allergies?  Yes  No

If yes, please list: \_\_\_\_\_

5. Have you ever had a surgical procedure or operation of any kind?  Yes  No

If yes, which type? \_\_\_\_\_

When MRI contrast is required for your exam, an IV injection of Gadolinium is used. The contrast material is a clear fluid, containing no iodine, which improves the ability of the radiologist to look at the MRI images and make a diagnosis. Rarely the injection of this contrast can result in an allergic reaction causing mild itching or rash (About 1 in 100 patients will have this kind of reaction.) Even more rare, a patient can have trouble breathing or a decrease in blood pressure (this occurs in about 1 in 300,000). In addition, patients may experience mild problems with their kidney function after the administration of this contrast. Nephrogenic Systemic Fibrosis (NSF), a very rare fibrosing condition of the skin and internal organs, has recently been reported to occur in patients with moderate to severe kidney failure who receives gadolinium contrast for MRI. It may be possible to perform the MRI study without contrast or to perform other diagnostic tests. However, these alternatives may keep your doctor from accurately diagnosing and managing your condition. For patients with no history of kidney failure, the risk of developing this condition is very small." In order to better assess your risk of having any of these very rare events, we are asking you these questions.

Contrast Risk Assessment:

6. Has patient had a prior MRI study that required injection of contrast media?  Yes  No

\* a. If yes, did the patient experience a reaction to the contrast media?  Yes  No

b. If yes, please specify symptoms: \_\_\_\_\_

\*7. Does the patient have a history of kidney disease?  Yes  No

If yes, is eGFR < 30 ?  Yes  No

Renal Function: eGFR: \_\_\_\_\_ Serum Creatinine: \_\_\_\_\_

\*8. History of diabetes mellitus?  Yes  No

I have read and fully understand the above questionnaire and all of my questions have been answered to my satisfaction. All responses are complete and correct to the best of my knowledge.

Patient Signature: \_\_\_\_\_  
Print Signature Date

Guardian Signature: \_\_\_\_\_  
Print Signature Date

Safety form reviewed by:

Front Desk: \_\_\_\_\_  
Print Signature Date Time

Technologist: \_\_\_\_\_  
Print Signature Date Time

Nurse/Expediter: \_\_\_\_\_  
Print Signature Date Time

\* If answer to questions number 2, 3, 6a, 7, or 8 is "Yes," then consult with an LIP for approval to perform this exam.



Dear Patient:

We currently participate with *Medicare* and the following *Managed Care* companies:

- Oxford*
- United HealthCare\**
- Aetna/US Healthcare*
- Empire Blue Cross/Blue Shield*
- Prucare*
- MagnaCare*
- National Benefits Fund (1199-NYU Member Choice Plan)*
- Cigna HMO/POS & PPO*
- Physicians Health Services (PHS)-Health Net*
- HIP – (of New York, Choice Card, Basic and VIP)*
- Vytra*

\*Faculty Practice Radiology does not participate with United Health Care Empire Plan and United HealthCare Medicaid Plan.

*If your insurance is with one of the Managed Care companies we participate with, an authorization number may be needed before we can perform your procedure.* If we have not obtained an authorization number from your physician prior to your arrival, your appointment may be delayed and/or you may have to pay for the study.

*If you are insured by another Insurance or Managed Care Company other than those listed above; you are responsible for payment whether or not your insurance company reimburses the service.* We will submit an insurance claim form on your behalf. You can expect to receive a statement from us within two weeks from the date of service.

I request that payment of *authorized insurance, Medicare benefits, Managed Care Company or reimbursing agency benefits* be made directly to NYU Faculty Practice Radiology for services furnished to me by its provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents or to an appropriate insurance company any information needed to determine those benefits, or the benefits payable for related services. I also certify that the information provided concerning my insurance coverage is correct.

Please indicate that you understand our financial policy by signing below. We acknowledge that we have discussed our financial policy with you today and given you a copy of this document to take with you.

Patient Name: \_\_\_\_\_

Patient/Guarantor Signature: \_\_\_\_\_

NYU Staff Member: \_\_\_\_\_

Date: \_\_\_\_\_

MRN: \_\_\_\_\_