GALAXY MRI

Warning! If have impaired kidney function, require kidney dialysis,or have a personal history of kidney disease, please notify a staff member IMMEDIATELY.

Today's Date________________________________ **Procedure**_________________________________

Referring Physician **Phone**

Patient Name_____________________________________ **DOB**_____________________ **Age**____________

Sex: Male / Female **Weight:** **Height**

Females Only: Date of last menstrual period?______________ **Chance of Pregnancy? Yes / No**

Are you breast-feeding? Yes / No Breast-milk should be discarded for 48 hours after injection.

Any Drug Allergies? Yes / No If yes, list____

Any severe allergies (not minor seasonal allergies)? Yes / No List:________________________________

Any previous allergic reaction to MRI contrast? Yes / No If yes,Explain:___________________________

Do you have diabetes? Yes / No

If yes, are you currently taking any medications containing metformin? These include Metformin (generic), Avandamet, Glucophage, Glucophage XR, Glucovance, and Metaglip.

Please remove all of the following:

Bra	**Purse/Wallet/Clips**	**Pencils/Pens**
Hairpins	**Keys/Coins**	**Hearing Aid**
Dentures/Partials	**Metal zippers/ Belt Buckle**	**Pocket Knife**

Do you have or history of any of the following?

Yes	No	
		Do you have poorly controlled Hypertension (Greater than 180-110 mmHg)
		Do you have cardiomyopathy or congestive heart failure?
		Do you have hemolytic anemia?

Yes	No		Yes	No	
		Heart Surgery/Cardiac Pacemaker or Valve			Back Surgery
		Stent/Coil/Filter			Ear/Cochlear Implants
		Staples/Clips/Metallic Sutures			Brain Surgery
		Aneurysm Clips where?			Neurostimulation System
		Implants where?			Biostimulator System
		Eyelid Wire			Bone Fusion Stimulator
		Penile Implants			Prosthesis where?
		Screws/Pins/Rods/Plates			Metal from GunShot wound
		I.U.D./Diaphragm			Hearing Aid
		Permanent MakeUp/Body Piercing/Tattoos			Medication Pump
		Cardiac Defibrillator			Dentures/Partials/Dental Implants
		Shunt			Medication Patch
		Radiation/Chemo Therapy			Swan Ganz Catheter/Pacing wires
		Any history of Cancer or Tumors?			Drug Infusion Pump
		Eye Surgery			Vascular Access Pump
		Sickle Cell Anemia/Disease			Any magnetically activated implant
		Stroke			Kidney/Bladder Disease/Transplant
		Liver Disorder			Asthma
		Seizures/Headaches/Dizziness			Respiratory Disease
		Injury to eye involving metal?			Welder now or in the past?
		Any metallic fragment or foreign body			Tissue expander (e.g., breast)

If yes,please explain____

I attest that the above information 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 the procedure I am about to undergo.

______________________________ ______________

Patient / Parent/ Legal Guardian Signature **Date**

______________________________ ______________

Hospital Supervising Nurse **Date**

______________________________ ______________

Technician Signature **Date**

Galaxy MRI

Patient Name:____ **DOB:**_________________________

CLINICAL USE ONLY

Patient Education: ☐ Verbal ☐ Brochure ☐ Video: Identify:____________________________

Discharge Instructions: ☐ Yes ☐ No Form:____

☐ **Not Applicable for this exam**

_____CC of ProhanceMagnevist Omniscan with a________@_______X_____________By___________________
Ga&Type Time # of Punctures Signature

in___________________________Lot#___________________________Expiration Date_______________________

Physician providing contrast coverage:____

Contrast Reaction ☐ Yes ☐ No Explain:____________________________________

Discharge instructions for Contrast Reaction given? ☐ Yes ☐ No

Discharge instructions for Contrast Extravasation given? ☐ Yes ☐ No