



## Breast MRI Questionnaire

Name \_\_\_\_\_ Age \_\_\_\_\_

Referring Doctor \_\_\_\_\_

Essential Information to be obtained at the time of breast MR scheduling:

### PRIOR EXAMS

Have you had a recent mammogram?  Yes  No

Have you had a recent breast ultrasound?  Yes  No

If so, where and when? \_\_\_\_\_

Have you ever had a breast MRI before?  Yes  No

If so, where and when? \_\_\_\_\_

If these exams were not performed in our office we will need you to bring the original exams and copies of your reports to our office on the day of your exam.

Have you ever had breast cancer?  Yes  No

If yes, when were you diagnosed? \_\_\_\_\_

If no, skip the next section, and go to family history of breast cancer.

What type of therapy did you receive?

Did you have breast surgery for cancer? (Lumpectomy or mastectomy) \_\_\_\_\_

Did you have radiation therapy?  Yes  No

Did you have chemotherapy?  Yes  No

Did you have hormonal therapy?  Yes  No

### FAMILY HISTORY OF BREAST CANCER

Have any of your blood relatives ever had breast cancer?  Yes  No

If yes, what relationship? \_\_\_\_\_

What age? \_\_\_\_\_

Are you a breast cancer gene carrier?  Yes  No  Unknown/never tested

What is the reason that your doctor has requested this exam? \_\_\_\_\_

\_\_\_\_\_



## Breast MRI Questionnaire (cont'd)

### SURGICAL HISTORY

Have you ever had a needle biopsy?

Yes

No

Have you ever had a surgical biopsy?

Yes

No

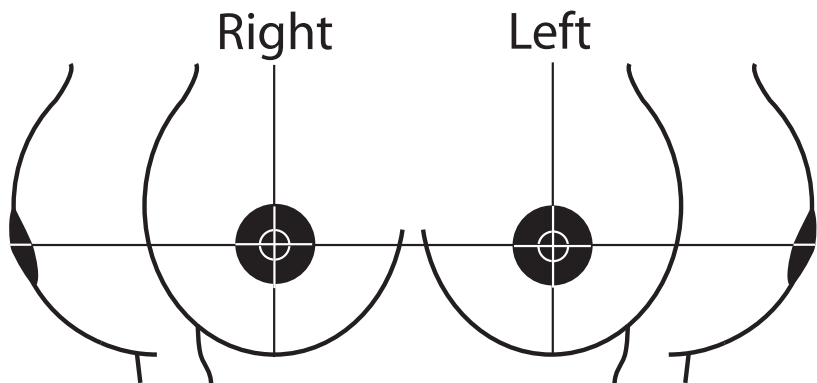
If yes, what were the results? \_\_\_\_\_

Did you ever have breast implants? If so what type (silicone or saline) and when were they placed?

\_\_\_\_\_

Do you have a breast lump?

Please indicate the location on this diagram.





### PATIENT SATISFACTION SURVEY

We are striving to provide you with the best possible care. Please help us to achieve this goal by taking a few minutes of your time to answer the following questions. In doing so you will help us to provide optimum care for all our patients.

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

Name: (optional) \_\_\_\_\_ E-mail: \_\_\_\_\_

Type of examination: \_\_\_\_\_

Was it easy to schedule your appointment for today's test?  Yes  No

If no, explain why? \_\_\_\_\_

Was your scheduler: *(Check all that apply.)*

- Courteous?  Yes  No
- Attentive to your needs?  Yes  No
- Efficient?  Yes  No

Was your examination started on time?  Yes  No

If not, how long did you wait for your examination:

- Less than 15 minutes
- 15 – 30 minutes
- 30 minutes or more

If more than 15 minutes, did someone explain the reason for delay?  Yes  No

Was your receptionist: *(Check all that apply.)*

- Courteous?  Yes  No
- Attentive to your needs?  Yes  No
- Efficient?  Yes  No

Was the technologist who performed the procedure: *(Check all that apply.)*

- Courteous?  Yes  No
- Attentive to your needs?  Yes  No
- Efficient?  Yes  No

If your exam required a Radiologist (Doctor): *(Check all that apply.)*

- Courteous?  Yes  No
- Attentive to your needs?  Yes  No
- Efficient?  Yes  No

Please rate your overall experience. *(Circle a number on the scale below to indicate your level of satisfaction)*

1 2  
⏟  
Poor

3 4  
⏟  
Fair

5 6  
⏟  
Satisfied

7 8  
⏟  
Very Satisfied

9 10  
⏟  
Excellent

Any additional comments that you can make would be helpful: *(The use of names would be helpful.)*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check here if willing to be contacted to provide an online review.

*Thank you for taking the time to complete this survey.*



## MRI SAFETY SCREENING SHEET

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

Age: \_\_\_\_\_

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

### **Do Not Enter Scan Room With These Or Any Magnetic Items:**

**Glasses-Removable Dental Work-Watch Or Jewelry  
Wallet-Credit Cards Or Metro Cards -Money Clips  
Pens- Pencils-Keys-Pocket Knife-Hair Pins-Barrettes  
Under Wire Supports-Safety Pins**

The Following Items May Interfere With MRI Imaging And Some Could Be Hazardous To Your Safety. Please Check Yes Or No To The Questions Below.

Cardiac Stimulator Or Pacemaker?	Yes___	No___
Brain Surgery Or Aneurysm Clips?	Yes___	No___
Carotid Artery Vascular Clamp?	Yes___	No___
Neuro Or Spinal Stimulator?	Yes___	No___
Artificial Heart Valve?	Yes___	No___
Insulin Or Drug Pump?	Yes___	No___
Cochlear (Ear) Implant?	Yes___	No___
Penile Implant?	Yes___	No___
Shrapnel Or Bullets?	Yes___	No___
Eye Injury Or Surgery?	Yes___	No___
Removable Dentures?	Yes___	No___
Any Kind Of Metallic Implant Or Fragment	Yes___	No___
Machinist Or Metal Worker?	Yes___	No___
Recent Tatoo?	Yes___	No___
Defibrillator?	Yes___	No___
Could You Be Pregnant?	Yes___	No___
Are You A Nursing Mother?	Yes___	No___
Contraceptive Diaphragm?	Yes___	No___

Patient's Signature: \_\_\_\_\_ Date\_\_\_\_\_



## **CONSENT FOR MRI SCAN WITH INTRAVENOUS CONTRAST**

Your Doctor has asked that an MRI scan be performed using intravenous contrast. This contrast may give the radiologist additional information that may not be available with a non-contrast scan. Please read the following information and if you are in agreement, sign and date the form. If you have questions regarding the form you may speak to a Radiologist prior to the scan.

On a few occasions patients have felt nauseous and some have vomited. A few have also experienced a mild allergic reaction and developed hives. This is usually self-limited or may be treated with an antihistamine. Rarely, patients may develop some respiratory difficulties or facial swelling. These can also be treated with medications which are immediately available. Most rare of all is the possibility that less than 1 out of 100,000 patients may experience an unpredictable serious reaction which may even result in death. This is an extremely rare complication and one for which the patient cannot be pre-tested. Nevertheless, intravenous contrast is generally very well tolerated.

Please answer the following question:

- 1) What is your weight?
- 2) Do you have any allergies to any medications or foods? If yes, please list.
- 3) Do you have asthma?
- 4) Do you have kidney disease or on dialysis?
- 5) Do you breastfeed?

I confirm that I have read and fully understand the above. I consent to having the MRI scan performed with the use of intravenous contrast.

PT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS: \_\_\_\_\_

INTERPRETER: \_\_\_\_\_

RADIOLOGIST: \_\_\_\_\_

PHYSICIAN ASS. \_\_\_\_\_



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## **PREGNANCY CONSENT FORM**

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

This examination requested by my physician is potentially harmful to my pregnancy, and may cause a miscarriage or congenital deformity. I understand this potential risk to the pregnancy and agree to have the examination performed as requested.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_