



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. _____



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.



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RADIOLOGY
PARTNERS**

East Manhattan Diagnostic Imaging

P: 212.410.5100 F: 212.410.2500

Union Square Diagnostic Imaging

P: 212.473.2300 F: 212.473.4780

Dove Open MRI

P: 212.683.6200 F: 212.683.2992

Kingsway Diagnostic

P: 718.758.1500 F: 718.758.2400

Columbus Circle Imaging

P: 212.977.4100 F: 212.977.4271

MUSCULOSKELETAL IMAGING QUESTIONNAIRE

NAME: _____ DATE: _____

What is the reason for this test? What are your symptoms and for how long have you experienced them?

Which side of the body does it affect? (Right or Left)

Has there been an injury to the area we are imaging today? If yes, please state the date and type of injury.

Have you had any surgeries performed on this area? If yes, please provide the date and type of surgery.

Have you had any prior X-rays, CT scan or MRI performed on this region? If yes, please state the results.

Do you have any medical illnesses? (E.g. Diabetes, Arthritis, Gout)



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_____



MRI PATIENT QUESTIONNAIRE:

The answers to these questions will be used by the Radiologist when your MRI is interpreted.

NAME _____ DATE _____

1) What are your symptoms?

2) What side of the body does it affect?

3) Have you had any prior radiology tests on this area?

4) Have you had any surgery on this area? When and what type?

5) Do you have high blood pressure/ hypertension? Yes No

6) Was there an injury or accident related to this problem?

7) Do you have diabetes? Yes No

8) Are you on dialysis, suffer from renal disease, or have had a kidney removed?

9) Do you have allergies? If yes, explain:



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East Manhattan Diagnostic Imaging

Union Square Diagnostic Imaging

Dove Open MRI

Kingsway Diagnostic

Columbus Circle Imaging

Morningside Medical

Midtown Medical Pavilion

Central Park Women's Imaging

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: _____