ALLIANCE
HEALTHCARE SERVICES

Place patient label here or enter
Patient name:

DOB _____

MRI PRE-CONTRAST SCREENING FOR IV CONTRAST

Your physician or radiologist may deem it necessary for you to have an IV injection of a contrast agent containing gadolinium to improve the quality of your MR examination.

Although gadolinium contrast agents have been used safely in millions of patients, minor reactions (principally headache or nausea), and serious or life threatening reactions may occur.

Have you ever had an injection of contrast before? ☐ Yes ☐ No

Have you ever had a previous reaction to contrast? ☐ Yes ☐ No

If yes, please explain: _____

Do you have a history of Diabetes? ☐ Yes ☐ No

Do you have a history of High Blood Pressure? ☐ Yes ☐ No

Are you receiving treatment for Gout? ☐ Yes ☐ No

Do you have a history of breast cancer with lymph nodes removed? ☐ Yes ☐ No

Do you have a history of Dialysis/Kidney Failure/Renal Insufficiency? ☐ Yes ☐ No
(If yes, also utilize Attachment A047- Consent for Gadolinium in Patients with Moderate/End Stage Renal Disease)

The technologist has explained the procedure to me and I have had my questions answered. I agree to have the MRI procedure with injection of contrast if deemed necessary.

_____ _____ _____

Signature of Patient (Parent or Guardian if patient is a minor or incapacitated) **Date** **Time**

GFR _____ (Document any contrast protocol modification on Part B)
Creatinine _____ Ref. Range_____-_____ Date_____

Contrast Name _____ Contrast Amount _____mL
Lot # _____ Contrast Expiration Date _____
Injection Site _____ Flow Rate _____
IV Device Used _____ Time of Injection_____ Tech Initials _____