## **MRI Part A - RETAIL** Last Name: Weight Height lbs/kgs First Name: The MRI room contains a very strong magnet and is ALWAYS on. You MUST remove all metallic objects. Hearing aids must be DOB: Date: removed immediately before entering the MRI room. Failure to remove such items can result in serious damage to those items and/or injury to yourself and others. Please answer the following questions carefully. Medical/Dental procedures with sedation in the past 24 hours? Yes No LVAD heart pump, pacemaker or pacer wires, defibrillator? Yes No Implanted neurostimulator or TENS unit? Yes No Medication injection device (OnPro) or pump? Yes No Artificial heart valves/stents or aneurysm/vascular clips/grafts/shunts? Yes No Breast tissue expander, metallic foreign body, bullet/shrapnel or any eye injury involving metal? Yes No Small bowel endoscopy capsule or Vena Cava umbrella filter? Yes No Recent colonoscopy or digestive system procedure involving surgical clips? Yes No Catheter- drainage tube or temperature monitor? Yes No Prior ear, eye or brain surgery? Yes No

Yes

Yes

Yes

Yes

Yes

Yes

**∃**Yes

Yes

**∃**Yes

Yes

Yes

Yes

No

## GENERAL CONSENT/ACKNOWLEDGEMENT

Anything in or on your body that you weren't born with?

List previous surgeries and dates:

Pregnant?

Hearing aids or Medication skin patches?

Joint Replacement or orthopedic/prosthetic device?

Tattoos/Body Piercings, Glitter/permanent makeup?

History of seizures or any recent falls? If yes, when?

LMP:

History of Cancer? If yes, what type

DriWeave, Dri Fit or wicking clothing?

Diarrhea in past 2-3 days?

Claustrophobia?

Iron deficiency being treated with Feraheme?

I consent to the ordered exam. I understand that I have the right to refuse or stop the exam at any time and I have the right to ask questions and discuss my concerns.

I have read the screening information and answered the above safety questions accurately, and I understand I MUST REMOVE ALL METAL prior to my MRI examination.

Hair extensions/wig, braces, oral springs, removable dental work or anything held with magnets/pins?

I authorize Akumin, its subsidiaries and affiliates to bill on my behalf Medicare, or any other insurance company providing benefits to me, for services performed by Akumin and I authorize payment to be made directly to Akumin. In Medicare assigned cases, Akumin agrees to accept the Medicare "allowable charge" as the full charge.

I understand that I am responsible for the payment of any patient liability including, but not limited to, deductibles, coinsurance or non-covered charges. Self-pay/Cash pay patients are expected to pay for services at the time services are rendered unless prior payment arrangements have been made.

I have been offered a printed copy of Akumin's Notice of Privacy Practices and I acknowledge receipt of the Patient Rights

and Responsibilities and the FDA GBCA Medication Guide	e (if contrast is to be administer	red).
I have read and I understand, acknowledge and agree to the answered. I give my consent to receive electronic communications and the second communication in the second communication is a second communication of the second communication is a second communication of the second communi		• •
Patient Signature:	Date:	Time:
(Parent or Guardian if patient is a Minor or Incapacitated)	Relationship:	
Reviewed Jan 2024		Attachment A007- RETAIL