DIAGNOSTIC RADIOLOGY ASSOCIATES
CONSENT FORM

1579 STRAITS TPKE
MIDDLEBURY, CT

WEIGHT _____

THIS QUESTIONAIRE IS DESIGNED TO ASSIST US IN DETERMINING IF IT IS SAFE FOR YOU TO UNDERGO A MAGNETIC RESONANCE PROCEDURE. IT IS IMPORTANT THAT YOU ANSWER ALL OF THE QUESTIONS. IF YOU DO NOT UNDERSTAND ANY QUESTIONS, PLEASE ASK FOR ASSISTANCE.

1. Do you have a pacemaker, wires, or implanted heart valve?	YES	NO	UNSURE
2. Have you ever had any head surgery requiring aneurysm clips?	YES	NO	UNSURE
3. Have you ever had any types of surgery? If so, please list:	YES	NO	UNSURE
_____			
4. Have you ever had a reaction to a contrast agent used for MRI, CT or X–Ray?	YES	NO	UNSURE
5. Do you have any surgically implanted metal of any type in your body?	YES	NO	UNSURE
6. Have you ever been exposed to metal fragments that could be lodged in your eyes or body?	YES	NO	UNSURE
7. Do you have a hearing aid, middle ear prosthesis or dentures?	YES	NO	UNSURE
8. Do you have any metal, pin, joint, prosthesis or metallic objects in, or attached to your body?	YES	NO	UNSURE
9. Do you have any type of electronic device (stimulator pump) in your body?	YES	NO	UNSURE
10. Do you have any tattoos, tattooed eyeliner, lip liner or body piercing? **NOTE: Please remove as much jewelry as possible.**	YES	NO	UNSURE
11. Do you wear a transdermal patch (nitro or nicotine)?	YES	NO	UNSURE
12. Do you have a history of panic attacks or a fear of enclosed or narrow places?	YES	NO	UNSURE
13. Do you have a history of drug or food allergies? If yes, please list:	YES	NO	UNSURE
_____			
14. Do you have a history of renal disease, seizure, asthma or emphysema?	YES	NO	UNSURE
15. If you are a female, are you pregnant, or is it possible you might be pregnant?	YES	NO	UNSURE
16. If you are a woman, are you breastfeeding?	YES	NO	UNSURE
17. Is there any other item or device you believe we should know about prior to doing this procedure? If yes, please describe.	YES	NO	UNSURE

I certify that I have read and understand the questions in this questionnaire and that the above responses are correct to the best of my knowledge. I understand that it is my responsibility to inform the center of any metal fragments and/or devices that may be in my body and that failing to do so may cause serious bodily injury or be life threatening. I agree that should I have any metal in my body and after consultation with a physician, elect to proceed with the MRI, I agree to release the center from any and all liability for injury.

_____ _____ DATE:_____
(PATIENT OR LEGAL REPRESENTATIVE) (PRINT NAME)

_____ _____ DATE:_____
(WITNESS) (PRINT NAME)

_____ _____ DATE:_____
(PHYSICIAN/TECHNOLOGIST/REGISTERED NURSE) (PRINT NAME AND TITLE)