



Consent for Magnetic Resonance Imaging (MRI) Contrast

Date: _____ Hour: _____ AM/PM

Dear Patient:

Your doctor has referred you for an MRI examination with contrast. This will necessitate an intravenous injection of a paramagnetic enhancement contrast medium. As with any medical procedure, it carries some risks, about which we think you should be informed.

In this procedure, a needle is introduced into one of your blood vessels. This needle is usually placed in your arm. Through this needle, a solution will be injected.

Patients understandably wonder what complications can occur from this procedure. It involves the injection of a solution into your blood stream. There are no known contraindications to the use of this material, however, the usual side effects which we would consider relatively minor but nevertheless can be distressing to patients are nausea, vomiting and a patient may experience the development of a transient headache. Other adverse reactions that have been reported in less than 1% of the patients include coldness, warmth, weakness, hypertension, pallor, gastrointestinal distress, agitation, dizziness, rash, sweating ringing in the ears and dry mouth. In extremely rare circumstances, more serious complications have been known to occur.

These reactions are uncommon and are transient and self-limited. Should you experience any of these reactions, we shall treat them with the appropriate medical care using all good and acceptable medical judgment and procedures.

If you would like more detailed information, or if you do not understand this form, we will be glad to discuss it with you.

I, _____ have read the above, that I fully understand it, and consent the
(Print Full Name)
use of this diagnostic material for an MRI examination.

(Witness)

(Patient's Signature)

(Date)

(Date)

If a patient is incapable of or incompetent to give consent or is a minor (under 18), complete the reverse side of this form.

PLEASE COMPLETE MEDICAL SECTION ON THE REVERSE SIDE

888-976-7472

I, _____ have read the above, and I fully understand it, and consent to
(Print Full Name)
the use of this diagnostic material for an MRI examination to be performed on:

(Patient)

(Witness)

(Signature of person authorized to consent for patient)
(Relationship)

(Date)

(Date)

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS

MEDICAL HISTORY:

Do you suffer from:

Heart disease/cardiac condition	Yes _____	No _____
Asthma	Yes _____	No _____
Liver disease (if yes)	Yes _____	No _____
BUN _____ Creatnine _____		
Renal (kidney) disease (if yes)	Yes _____	No _____
BUN _____ Creatnine _____		
Seizure disorder	Yes _____	No _____
Anemia/blood disorder	Yes _____	No _____
Allergic/Respiratory disease	Yes _____	No _____
Lactation	Yes _____	No _____
Allergies to Medication	Yes _____	No _____
Diabetes (if yes)	Yes _____	No _____
BUN _____ Creatnine _____		

If so, which drugs:

Are you taking any prescribed medications at this time? Yes _____ No _____

Is so, which drugs:

