Intermountain McKay-Dee Hospital
Healing for life®

MRI ABDOMEN HISTORY FORM

Name: _____

Date:_____

1. What is the **MAIN REASON** for this exam? _____

2. Have you had a CT or MRI of the same area before? □ YES □ NO

   If yes, where and when: _____

3. Please circle all that apply: Other: _____

Upper abd pain	RT	LT	Vomiting	Blood in urine	Cramping pain
Lower abd pain	RT	LT	Diarrhea	Blood in stool	Constipation
Flank pain	RT	LT	Nausea	Abd distention	Heartburn/reflux
Groin pain	RT	LT	Loss of appetite	Sharp pain	High blood pressure
Back pain	RT	LT	Pain with eating	Dull aching pain	Artery disease

4. When did symptoms start and how frequently do you get them? _____

   _____

5. Circle any prior **ABDOMINAL SURGERY:** Other: _____

Appendectomy	Cholecystectomy	Splenectomy	Pancreatectomy
Bladder surgery	Small intestine resection	Removal of ovaries	Aortic or artery surgery
Liver surgery	Bile duct surgery	Hysterectomy	Removal of colon

6. Have you had a significant recent abdominal injury? □ YES □ NO

   If yes, please give a brief description and approximate date: _____

7. Do you have any known cancer? □ YES □ NO

   If yes, what type and when diagnosed: _____

   Have you had radiation treatment on your **ABDOMEN**? □ YES □ NO

   Can you or your doctor currently feel an abdominal mass? If so, where? _____

10. Please provide additional information that is important for the radiologist to know:

    _____

    _____

IMG ASSESSMENT

Intermountain
McKay-Dee Hospital
Healing for life®

Date: _____

MRI SCREENING FORM

Name: _____ **Date of Birth:** _____ **Height:** _____ **Weight:** _____

⚠	**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

Please indicate if you have any of the following:

Yes	No	
☐	☐	Cardiac Pacemaker
☐	☐	Implanted Defibrillator
☐	☐	Aneurysm Clip
☐	☐	Tissue Expander (e.g., breast)
☐	☐	Neurostimulation device
☐	☐	Spinal Cord Stimulator
☐	☐	Internal Electrodes or Wires
☐	☐	Bone Growth/Bone Fusion Stimulator
☐	☐	Cochlear, Otologic, or Other Ear Implant
☐	☐	Swan-Ganz or Thermodilution Catheter
☐	☐	A Colonoscopy or Endoscopy Clip Placed in the last 10 days
☐	☐	Pregnant

If you checked "YES" to any of the above items, STOP and contact the ordering physician, clerk, nurse or MRI technologist.

☐	☐	Hearing aid (remove before entering MRI area)
☐	☐	Artificial or Prosthetic Limb
☐	☐	Tattoo or Permanent Makeup
☐	☐	Medication Patch (Nicotine, Nitroglycerin, etc. These may need to be removed)
☐	☐	Any Metallic Fragment, Foreign Body or Shrapnel. If yes, where in the body? _____
☐	☐	Insulin or Other Medication Infusion Pump
☐	☐	Diabetic
☐	☐	Impaired Kidney Function
☐	☐	Loop Recorder
☐	☐	MRI IV Contrast Reaction

MRI exams take approximately 40 minutes for each area being evaluated. Remove watches, hairpins, and all pocket items including wallets and credit cards. Please leave these items at home or with family members. A locker will be provided, but we will not be responsible for lost or misplaced items. To protect your hearing during the exam you will be given ear protection prior to imaging.

Patient Signature: _____ Clerical Initials: _____ Technologist Review: _____

IMG ASSESSMENT

Acknowledgement of Radiology Contrast Education

Patient ID_____

You are scheduled to have a radiology exam that includes the injection of intravenous (IV) contrast material. The use of contrast for this procedure greatly improves the exam quality.

Here are a few basic details about IV contrast:

- **Injection**: The injection requires a needle to be placed in your arm. This should be no more painful than an average blood test.
- **Sensations**: During the injection, you may feel warm or cool sensations, metallic taste, dizziness, or slight nausea which should pass quickly. Please keep in mind that most patients have no problem with the injection.
- **Risks**: As with any medication, there are possible risks when contrast is used. There may be some local pain at the injection site, and there is a very small risk of local tissue damage if the IV fails. The medication may cause an allergic reaction with itching, hives, or a rash. Rarely, a more serious reaction can occur. This may include fainting, swelling, shortness of breath, or a heart problem. **Please let your technologist know if you have experienced a reaction like this to contrast in the past.** In rare cases, contrast can cause kidney failure (especially with people who have diabetes or kidney disease)—be sure to tell us if you have diabetes or kidney disease. Very rarely, loss of life has been reported. Because we are very aware of the risks, we will observe you throughout the procedure. If a complication happens, we are prepared to treat it right away.

If the information above raises further questions in your mind, a physician is available to answer them. If you would like to speak to a physician to discuss your concerns, please let us know before we start the exam.

Please sign below to show that you have read and understand this information.

Patient, Parent, or Guardian Name (*please print*)_____

Patient, Parent, or Guardian Signature_____ Date_____ Time_____

Interpreter's Name (*if applicable*)_____

Unable to obtain signature, reason:_____

Technologist Signature_____ Date_____ Time_____