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

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

3. Do you have pain? □ YES □ NO If yes, describe frequency and location:__________
_____________________________________________________________________________

4. Have you ever had a significant injury to the area? □ YES □ NO If yes, please give a brief
description and approximate date.
_____________________________________________________________________________
_____________________________________________________________________________

5. Do you have any of the following FACIAL symptoms?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Right</th>
<th>Left</th>
<th>Date of Onset:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numbness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weakness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

6. Do you have any of the following eye symptoms?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Right</th>
<th>Left</th>
<th>Date of Onset:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision Loss</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Bulging</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Pain</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. Do you have any of the following ear symptoms?

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Right</th>
<th>Left</th>
<th>Date of Onset:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing Loss</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ringing (tinnitus)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. Do you have any known cancer? □ YES □ NO
   If yes, what type, when was it diagnosed?
_____________________________________________________________________________

   Have you ever had radiation treatment that included your **HEAD**? □ YES □ NO
_____________________________________________________________________________

   Have you ever had chemotherapy? □ YES □ NO If yes, when? ______________
_____________________________________________________________________________

9. Do you or your doctor currently see or feel a mass in the area we are examining? □ YES □ NO

10. Circle any of the symptoms that apply:

    Dizziness   Difficulty Walking   Headaches

MRI Orbit Face Neck History Form
Form # MKIM7122
03/27/2017
©IHC Health Services, INC, 2017
MRI SCREENING FORM

Name: ___________________________________ Date of Birth: ___________ Height: _______ Weight: _______

Please indicate if you have any of the following:

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
| ☐   | ☐  | 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.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>
| ☐   | ☐  | 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: _______

MRI Screening Form
Form # MKIM7124
03/27/2017
©IHC Health Services, INC, 2017

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.
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____

ACKNOWLEDGEMENT OF RADIOLOGY
CONTRAST EDUCATION
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Intermountain Healthcare