

MRI ANKLE 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
Where and when: _____

3. Circle what part of your ankle hurts:

Front Back Outside Inside Deep in Joint

4. Are the symptoms due to an injury? YES NO
Please describe and give injury date: _____

5. Circle the description that most applies to your ankle:

Weakness Numbness Locking Popping Catching

Limited Motion Prior Fracture Burning Instability Discoloration

6. Have you ever dislocated your ankle? YES NO
How often and most recent dislocation: _____

7. Have you had **ANKLE SURGERY**? YES NO
What surgery and when: _____

8. Have you had an ankle injection for the treatment of pain? YES NO
How long ago? _____

9. Do you have any known cancer? YES NO
What type and when diagnosed: _____
Have you had radiation treatment on your **ANKLE**? YES NO
Do you have an ankle mass? YES - where: _____

10. Circle any of the following that apply to you:

Diabetes Prednisone Use Smoking Heart or Artery Disease

Gout Rheumatoid Arthritis Osteoarthritis Bone Infection

Erosive Osteoarthritis Bone Infarctions Reiter's Disease

Arterial Vascular Necrosis Psoriasis Osteoporosis Ankylosing Spondylitis



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 | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Implanted Defibrillator |
| <input type="checkbox"/> | <input type="checkbox"/> | Aneurysm Clip |
| <input type="checkbox"/> | <input type="checkbox"/> | Tissue Expander (e.g., breast) |
| <input type="checkbox"/> | <input type="checkbox"/> | Neurostimulation device |
| <input type="checkbox"/> | <input type="checkbox"/> | Spinal Cord Stimulator |
| <input type="checkbox"/> | <input type="checkbox"/> | Internal Electrodes or Wires |
| <input type="checkbox"/> | <input type="checkbox"/> | Bone Growth/Bone Fusion Stimulator |
| <input type="checkbox"/> | <input type="checkbox"/> | Cochlear, Otologic, or Other Ear Implant |
| <input type="checkbox"/> | <input type="checkbox"/> | Swan-Ganz or Thermodilution Catheter |
| <input type="checkbox"/> | <input type="checkbox"/> | A Colonoscopy or Endoscopy Clip Placed in the last 10 days |
| <input type="checkbox"/> | <input type="checkbox"/> | Pregnant |

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

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Hearing aid (remove before entering MRI area) |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial or Prosthetic Limb |
| <input type="checkbox"/> | <input type="checkbox"/> | Tattoo or Permanent Makeup |
| <input type="checkbox"/> | <input type="checkbox"/> | Medication Patch (Nicotine, Nitroglycerin, etc. These may need to be removed) |
| <input type="checkbox"/> | <input type="checkbox"/> | Any Metallic Fragment, Foreign Body or Shrapnel. If yes, where in the body? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Insulin or Other Medication Infusion Pump |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetic |
| <input type="checkbox"/> | <input type="checkbox"/> | Impaired Kidney Function |
| <input type="checkbox"/> | <input type="checkbox"/> | Loop Recorder |
| <input type="checkbox"/> | <input type="checkbox"/> | 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: _____



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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