

PLEASE COMPLETE ENTIRE FORM FRONT AND BACK.

OFFICE USE ONLY

MRN # _____

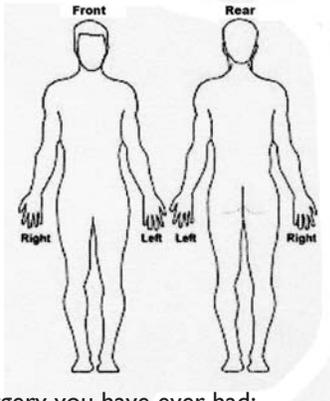
PATIENT INFORMATION

Name: _____
Date of Birth: _____ Male Female
Height: _____ Weight: _____

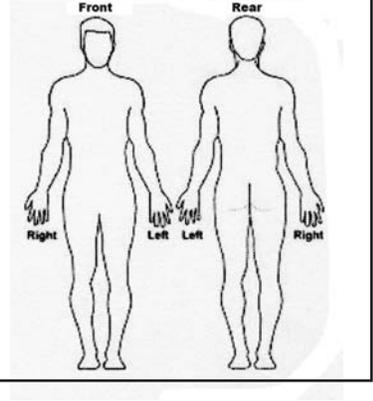
REASON FOR MRI AND/OR SYMPTOMS

Where are your symptoms?

- X** = Where you hurt most
- A** = Aching
- W** = Weakness
- N** = Numbness
- P** = Pins/needles
- S** = Stabbing
- B** = Burning
- O** = Scar



Please mark on this drawing the location of any metal inside your body, or site of Surgical operation.



1. Please list any type of surgery you have ever had:

Type of Surgery _____ Date ___/___/___
Type of Surgery _____ Date ___/___/___

Type of Surgery _____ Date ___/___/___
If you have had additional surgeries, please list on back side.

2. Are you allergic to any medications? Yes ___ No ___ If yes, please describe: _____
(If additional space is needed, please list on back side.)
3. Have you ever experienced any problem related to a previous MRI exam or had a gadolinium reaction to MRI contrast agent/dye? If yes, please describe: _____
4. Do you have a history of Renal (Kidney) disease, asthma, allergic reactions or respiratory disease? Yes ___ No ___
5. **Have you had an injury to the eye involving a metallic object or fragment (eg. Metallic slivers, shavings, or foreign body)?** If yes, please describe _____

Carefully answer YES or NO to ALL of the following items. Certain implants, devices, or foreign objects in your body may interfere with the exam and be hazardous to your safety.

- Yes No **Are you taking Feraheme for Anemia? (See back)**
- DO YOU HAVE:**
- Yes No Aneurysm clip(s)
 - Yes No Cardiac Pacemaker
 - Yes No Implanted Cardiac Defibrillator (ICD)
 - Yes No Internal Electrodes or Wires
 - Yes No Any type implant held in place by a magnet
 - Yes No Electronic, Magnetically-activated Implant or Device
 - Yes No Neurostimulator or Biostimulator System
 - Yes No Spinal Cord Stimulator
 - Yes No Cochlear, Otologic, or other Ear implant
 - Yes No Insulin or other medication Infusion Pump
 - Yes No Any type of Prosthesis (Heart, Eye, Penile, etc.)
 - Yes No Eyelid Spring or Wire
 - Yes No Artificial or Prosthetic Limb
 - Yes No Metallic Stent, Filter, or Coil

- DO YOU HAVE:**
- Yes No Shunt (Spinal or Intraventricular)
 - Yes No Vascular Access port and/or Catheter
 - Yes No Radiation Seeds or Implants
 - Yes No Medication Patch (Nicotine, Pain, Nitroglycerine)
 - Yes No Any Metallic Fragment or Foreign Body
 - Yes No Tissue Expander (Breast)
 - Yes No Surgical Staples, Clips, or Metallic Sutures
 - Yes No Bone/Joint Pin, Screw, Nail, Wire, or Prosthesis
 - Yes No IUD, Diaphragm or Pessary
 - Yes No Dentures or Partial Plates (Please remove for exam)
 - Yes No Tattoo or Permanent Makeup
 - Yes No Body Piercing Jewelry
 - Yes No Hearing Aid (Please remove for exam)
 - Yes No Any Implanted Medical Object/Device

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form. I have had the opportunity to ask questions regarding the information on this form and the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date: _____

Form Completed By: Patient Relative Nurse / Print Name: _____ Relationship to Patient: _____

Signature of Tech Assistant Reviewing Form: _____ Date: _____

Signature of PDI Technologist Reviewing Form: _____ Date: _____

Continued from front side.

Please list any type of surgery you have ever had:

Type of Surgery _____ Date ___/___/___ Type of Surgery _____ Date ___/___/___

Type of Surgery _____ Date ___/___/___ Type of Surgery _____ Date ___/___/___

Additional medicines you are allergic to: _____

Important Safety Information about Feraheme

Feraheme can cause unusual results with magnetic resonance imaging (MRI) tests for up to 3 months after your last dose. This can result in a missed diagnosis or the need for a repeat MRI. Tell any doctor who treats you that you have received a ferumoxytol injection within the past 3 months.

Instructions for the MRI Patient

Do not enter the MRI system room or MRI environment if you have any questions or concerns regarding an implant, device or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room.

1. Remove any medication patch whether it's a (Nitroglycerine, Nicotine, Pain etc.) to prevent overheating and malfunction of the medication delivery system while in the MRI magnet.
2. Remove all jewelry, and lock it in the locker provided for you.
(Ex. necklaces, pins, rings)
3. Remove all hair pins, bobby pins, barrettes, clips, and lock them in the locker provided for your use.
4. Wigs will need to be removed just prior to going in the scan room.
5. Remove all dentures, false teeth, and partial dental plates prior to the MRI.
6. Lock the following items in the locker provided for you: (wallet, purse, watch, pager, cell phone).
7. Remove all body piercing jewelry and lock them in the locker provided for your use.
8. Remove hearing aides just prior to going in the scan room. This will enable us to still communicate well during the interview process.
9. FEMALES: You are required to remove your bra due to the metal clips or underwire that will cause artifacts with your images.
10. Let the technologist know if this is a follow-up to a previous test performed at Premier, or another medical facility.
11. You will be instructed to use the ear plugs or headphones we supply during your MRI examination as a hearing protective device as loud noises are generated during the MR procedure.