Montclair Breast Center

MRI CONSENT FOR IV CONTRAST INJECTION

PATIENT NAME:_____

DATE OF BIRTH:_____ AGE:_____

This examination requires an intravenous injection of gadolinium. This contrast media have been shown to have lower incidence of severe adverse reactions. Identified below are guide lines recommended by the American College of Radiology.

Have you ever had a gadolinium injection? Yes:_____ No:_____

Did you have any problems? Yes:_____ No:_____

If yes, when and what happened?_____

DO YOU HAVE?

Allergies to iodine? ☐Yes ☐No

Other allergies (list):_____

Emphyserna ☐Yes ☐No

Hay Fever ☐Yes ☐No

High Blood Pressure ☐Yes ☐No

Sickle Cell Anemia ☐Yes ☐No

Diabetes ☐Yes ☐No Treatment: _____

Asthma ☐Yes Treatment:_____ ☐No

Heart Problems ☐Yes Treatment:_____ ☐No

Kidney Problems ☐Yes Treatment:_____ ☐No

Liver Problems ☐Yes Treatment:_____ ☐No

Are you pregnant ☐Yes Last Period:_____ ☐No

Do you take medications ☐No Yes(names):_____

I UNDERSTAND

My doctor has requested the performance of a magnetic resonance imaging examination study with a contrast agent, of which there are no known contraindications. I understand that this MRI study requires am injection into my vein. The agent is promptly excreted by kidneys where it is emptied from the body upon urinating. Because the compound is paramagnetic, it is visible on the MRI scan and permits a detailed analysis.

Although the procedure is generally safe, a very small number of people will by sensitive to the drug, I understand that a small number of patients may, after injection, have a localized feeling of warmth, and may occasionally have coldness, burning, substernal chest pain, fever or hypotension. However, these symptoms occur in less that 1% of the patients. These are mild symptoms and usually pass quickly.

The latest information available indicated that in the United States and Europe, the death rate for patients undergoing this injection is zero percent (0%). However, all precautions will be taken and any symptoms monitored carefully.

I received a copy of medication guidelines. I have had the opportunity to ask questions about the procedure and the risks associated with it and I have no further questions. I give my consent to have this study performed.

PATIENT SIGNATURE _____ **DATE:** _____

PATIENT SIGNATURE IF MINOR _____ **RELATIONSHIP TO PATIENT** _____

(FOR RADIOLOGY USE ONLY): _____ Name of Procedure: **MRI BREAST**

Drug and does contrast injected: Dotarem Gadavist Clariscan Date injected _____

Lot #_____ Time Injected _____ Injection site_____

name of person administering contrast media_____

Name of assigned reading Radiologiest: Dr. Lee☐ Dr. Ameri ☐

Patient refused contrast_____

SIGNATURE TECHNOLOGIST _____ **DATE** _____

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