

NEXTGEN M.D.

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Patient Information

First Name:	
Middle Name:	
Last Name:	
Address:	
Sex: <input type="radio"/> Male <input type="radio"/> Female	
Height:	Weight (lbs):
Date of Birth:	Age:
Email Address:	Mobile Number:
Referring Physician:	
Are you pregnant? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> N/A	
Last Menstrual Period:	
Reason you are here today:	

Explain your medical problem in detail. (What happened? Where did it happen? How long have you had this problem?)

Do you have pain? <input type="radio"/> Yes <input type="radio"/> No	Where?
Have you had any surgeries in the area(s) that are being imaged today? <input type="radio"/> Yes <input type="radio"/> No	
Where?	
Have you taken any medication/sedation/alcohol today to help you relax for this procedure? <input type="radio"/> Yes <input type="radio"/> No	
If yes, please list:	Time Taken:
Have you had a previous exam related to this problem? <input type="radio"/> Yes <input type="radio"/> No	
If yes, explain:	

Patient Information

Do you have any of the following?

- Heart Surgery/Heart Valve)
- Brain Surgery/Brain Aneurysm Clips
- Shunts/Stents/Intravascular Coil
- Eye Surgery/Implants
- Injury to eye involving metal or metal shavings
- Penile Prosthesis
- Orthopedic Pins/Rods/Screws/Plates/etc.
- Neurostimulator/BioStimulator
- Radiation Therapy/Chemo Therapy
- History of Cancer or Tumor
- Surgery on spine (Neck or Back)
- Hearing Aids/Ear Surgery/Cochlear Implants
- Vascular Access Ports
- IUD/Diaphragm/Pessary
- Metal/Mesh Implants/Wire Sutures/ Staples/Internal Electrodes Any type of Electrical/Magnetic/
Mechanical Implants in your body
- Implanted Cardiac Pacemaker or Defibrillator
- Pacing Wires/Swan-Ganz Catheter
- Are you pregnant? Last Menstrual Period
- Tattoos/Permanent Make-up/ Body Piercings, Hair Extensions
- Dentures/Partials/Dental Implants Gunshot Wounds/ Shrapnel/ BB's Seizures/Headaches/Dizziness
- Asthma/Allergic Respiratory Disease
- Blood disorder/ Sickle Cell Anemia Are you breast feeding at this time?
- Have you ever had a reaction to MRI contrast in the past?
- Stroke
- Kidney Disease
- Liver Disorder

Please explain for each "yes" above

List any drug allergies

List all surgeries in your lifetime

Patient Information

List all medications you are currently taking

List all locations of your pain or symptoms on your body

List all locations of any metal in your body

- Acknowledgement: I have answered these questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that at this time I am pregnant OR NOT pregnant.

Patient/Parent/Legal Guardian Signature

Date

Magnetic Resonance Imaging (MRI) Consent Form

You have the right to be informed about the recommended diagnostic procedure to be used, so that you may make the decision whether or not to undergo this procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you. It is so that you can choose to give or withhold your consent to the procedure.

If you are pregnant or think you may be pregnant, please inform center personnel at once. It is very important that you inform the technologist if you have a heart valve, a pacemaker, aneurysm clips, or other implanted metal or electrical devices.

Your physician has requested a magnetic resonance imaging (MRI) examination to obtain additional information. MRI uses a magnetic field and radio waves to produce images of the body part being examined. MRI does not use x-rays or radiation and is painless. Some scanners may produce loud repetitive noises throughout the procedure therefore, headphones or earplugs will be provided.

A contrast may be injected as part of your MRI to provide better images of the part of the body being examined.

Potential Risks: The following complications are possible anytime an injection is given: potential for pain, bleeding, bruising or swelling at the injection site. MRI exams requiring contrast may result in: mild headache, nausea, itching or other vague symptoms for a short time after the injection.

Additional allergic reactions in response to the contrast agent may include: hives, shortness of breath or difficulty in swallowing. There have been rare instances of death after the administration of the contrast agent. It is very important that you inform the technologist if you experience any of the conditions mentioned in this form.

If you have previously had a reaction to a contrast injection such as hives, shortness of breath, any significant reaction requiring hospitalization, a history of asthma or other allergic conditions, any history of anemia, sickle cell anemia or kidney disorder; or if you are breastfeeding you must inform the technologist. The safety of contrast in children under 2 has not been established.

The diagnostic test being performed was ordered by your physician based on your symptoms and condition. The benefits of this exam are to assist your physician with a diagnosis.

In conjunction with the American College of Radiology (ACR) guidelines, it is the policy of One Step Diagnostic to identify patients at risk of developing Nephrogenic Systemic Fibrosis (NSF) prior to any Gadolinium-Based Contrast Agent (GBCA) injection. The method used to identify such patients require assessing renal function at the time of service.

Using a point of service device, a serum creatinine level is acquired and used to calculate the current estimated Glomerular Filtration Rate (eGFR). If provided, you and/or your insurance company will be billed for this service.

- I (WE) CERTIFY THIS FORM HAS BEEN FULLY EXPLAINED TO ME, THAT I (WE) HAVE READ IT, OR HAVE HAD IT READ TO ME (US), THAT THE BLANK SPACES HAVE BEEN FILLED IN AND THAT I (WE) UNDERSTAND ITS CONTENTS. I (WE) HAVE SUFFICIENT INFORMATION REGARDING THE PROCEDURE(S) AND THE RISKS AND HAZARDS INVOLVED.

Patient Name Printed:	Patient Signature
Date:	Time:
Witness Name Printed	Witness Signature
Date:	Time:
Claustrophobic: Y or N:	Diabetic: Y or N :
HBP: Y or N:	Allergic to Iodine: Y or N:
Allergies: Y or N:	Surgery
Pregnant/Breastfeeding: Y or N	
Kidney Problems: Y or N:	Does PT have an implant card? Y or N:
Pacemaker/Metal /Implants/Pain Pumps/Neurostimulator/Stents:	

Visitor Screening Questionnaire

Within the past 14 days, I have traveled to a location where COVID-19 has been diagnosed or suspected: Y or N

Within the past 14 days, I have been in close contact with persons who have traveled to a location where COVID-19 has been diagnosed or suspected: Y or N

Within the past 14 days, I have been sick with a cold or flu: Y or N

Within the past 7 days, I have had a fever: Y or N

Within the last 7 days, I have had nausea and vomiting and/or loss of taste and /or smell: Y or N

Within the last 7 days, I have had diarrhea: Y or N

I now have symptoms of a cold or flu: Y or N

I now have a fever: Y or N

Within the past 14 days, I have been around people who have been or are sick with colds or flu: Y or N

I have been nauseated or have vomited or had diarrhea within the past week: Y or N

I have received the COVID-19 Vaccination: Y or N - if yes, please indicate which arm.

Identification Card: Please upload your picture ID card.

Please review to ensure the details are correct before completion.