BREAST MAGNETIC RESONANCE IMAGING (MRI)

Date_____/_____/_____ Chart # _____

Patient name _____

Date of Birth_____/_____/_____Age_____Height_____Weight_____

Breast Magnetic Resonance Imaging (MRI) is one of the most advanced diagnostic imaging tools available in medicine today. Using magnetic fields and radio frequency coils, detailed cross-sectional images of your breasts are obtained to further evaluate them. **MRI does *NOT* use radiation and is completely painless.** There are no known side effects Your examination will be performed by a highly skilled Registered Technologist under the supervision of the Clinical Breast Radiologist.

1. Have you had a prior MRI diagnostic imaging study? ❑ Yes ❑ No
   If yes, please list: Body part Date Facility

   _____ _____ _____

   _____ _____ _____

2. Have you ever been diagnosed with breast cancer? ❑ Yes ❑ No If yes, year? _____
   a. Have you ever had chemotherapy? ❑ Yes ❑ No
   b. Have you ever had radiation ❑ Yes ❑ No
   ❑ If yes, which type? Partial Whole
   c. Have you ever taken anti-hormonal therapy? ❑ Yes ❑ No
   ❑ If yes, how long? _____

3. Have you experienced any problem or reaction to a previous MRI exam (e.g., shortness of breath, rash, etc.)? ❑ Yes ❑ No
   If yes, please describe reaction: _____

4. Have you had an injury to the eye involving metallic substances (e.g., metal slivers, shavings, foreign body, etc.)? ❑ Yes ❑ No
   If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ❑ Yes ❑ No
   If yes, please describe: _____

6. Are you currently taking or have you recently taken any medication? ❑ Yes ❑ No
   If yes, please list: _____

7. Are you allergic to any medication? ❑ Yes ❑ No
   If yes, please list: _____

8. Date of last menstrual period:_____/_____/_____ Postmenopausal? ❑ Yes ❑ No
   a. If post menopausal, are you **currently** on hormone replacement therapy (HRT)? ❑ Yes ❑ No
   If yes, please list name of hormone:_____ how long? _____
   b. If not currently on HRT, were you ***ever*** on HRT in the past? ❑ Yes, how long?_____ ❑ No

9. Please answer ***yes*** or ***no*** below:
   a. Are you pregnant ***or*** experiencing a late menstrual period? ❑ Yes ❑ No
   b. Are you ***currently*** breastfeeding? ❑ Yes ❑ No
   c. Has your uterus been removed? ❑ Yes ❑ No
   d. Have your ovaries been removed? ❑ Yes ❑ No
   e. Have you had uterine ablation? ❑ Yes ❑ No
   f. Are you ***currently*** taking birth control? ❑ Never ❑ Yes, how long? ____ ❑ Previously, how long? ____
   g. Do you ***currently*** have an IUD in place? ❑ Yes ❑ No

10. Are you **currently** taking any type of fertility medication or having fertility treatments? ❑ Yes ❑ No
    If yes, please list: _____

11. Have you **ever** taken fertility medication in the past? ❑ Yes ❑ No
    If yes, please list: _____

Please indicate if you have any of the following:

❑ Yes ❑ No	Kidney disease	❑ Yes ❑ No	Kidney failure
❑ Yes ❑ No	Kidney transplant	❑ Yes ❑ No	Anemia or any blood disease
❑ Yes ❑ No	Liver (hepatic) disease	❑ Yes ❑ No	Seizures
❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Hypertension (high blood pressure)

If yes to any above, please list medications: _____

_____

❑ Yes ❑ No	Aneurysm clip(s)	❑ Yes ❑ No	Vascular access port and/or catheter
❑ Yes ❑ No	Cardiac pacemaker or lead	❑ Yes ❑ No	Radiation seeds or implants
❑ Yes ❑ No	Electronic implant or device	❑ Yes ❑ No	Any metallic fragment or foreign body
❑ Yes ❑ No	Magnetically-activated implant or device	❑ Yes ❑ No	Wire mesh implant
❑ Yes ❑ No	Neurostimulation system	❑ Yes ❑ No	Tissue expander (e.g., breast)
❑ Yes ❑ No	Spinal cord stimulator	❑ Yes ❑ No	Surgical staples, clips, or metallic sutures
❑ Yes ❑ No	Internal electrodes or wires	❑ Yes ❑ No	Joint replacement (hip, knee, etc.)
❑ Yes ❑ No	Bone growth/bone fusion stimulator	❑ Yes ❑ No	Bone/joint pin, screw, nail, wire, plate, etc.
❑ Yes ❑ No	Cochlear, otologic, or other ear implant	❑ Yes ❑ No	Shunt (spinal or intraventricular)
❑ Yes ❑ No	Insulin or other infusion pump	❑ Yes ❑ No	IUD, diaphragm, or pessary
❑ Yes ❑ No	Implanted drug infusion device	❑ Yes ❑ No	Dentures or partial plates
❑ Yes ❑ No	Eye prosthesis or lens implants	❑ Yes ❑ No	Tattoo or permanent makeup
❑ Yes ❑ No	Heart valve prosthesis	❑ Yes ❑ No	Body piercing
❑ Yes ❑ No	Eyelid spring or wire	❑ Yes ❑ No	Breathing problem or motion disorder
❑ Yes ❑ No	Artificial or prosthetic limb	❑ Yes ❑ No	Hearing aid
❑ Yes ❑ No	Stent, filter, or coil		***(Remove before entering MR system room)***
❑ Yes ❑ No	Breast Implants	❑ Yes ❑ No	Claustrophobia
	If yes, are they: ❑ *Saline or* ❑ *Silicone*		

Before entering the MRI environment, you ***MUST REMOVE*** all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern ***BEFORE*** you enter the MRI environment.

NOTE: You will be required to wear earplugs during the MRI procedure.

I understand that I will receive an injection (usually in the arm) of a contrast enhancement agent called gadolinium that helps to highlight various structures in the breast tissue. The gadolinium is administered through a small intravenous catheter which is placed by a certified technologist or registered heath care professional.

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

Signature of Person Completing Form:_____ Date_____/_____/_____

Form Completed By: ❑ Patient ❑ Relative ❑ Nurse _____ _____

Print name Relationship to patient

Form Information Reviewed By: _____ _____

Print name Signature

❑ MRI Technologist ❑ Radiologist ❑ Other _____