



BREAST MAGNETIC RESONANCE IMAGING (MRI)

Date ____/____/____ Chart # _____

Patient name _____

Date of Birth ____/____/____ Age ____ Height ____ Weight ____

Reason for MRI and/or Symptoms _____

Referring Physician _____

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? ... Facility
2. Have you experienced any problem or reaction to a previous MRI exam...
3. Have you had an injury to the eye involving metallic substances...
4. Have you ever been injured by a metallic object or foreign body...
5. Are you currently taking or have you recently taken any medication?
6. Are you allergic to any medication?
7. Date of last menstrual period... Postmenopausal?
8. Please answer yes or no below:
9. Are you currently taking any type of fertility medication...
10. Have you ever taken fertility medication in the past?

Please indicate if you have any of the following:

- | | | | |
|----------------------------------------------------------|-------------------------|----------------------------------------------------------|------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney failure |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney transplant | <input type="checkbox"/> Yes <input type="checkbox"/> No | Anemia or any blood disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver (hepatic) disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Hypertension (high blood pressure) |

If yes to any above, please list medications: _____

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