Weill Cornell Imaging

NewYork-Presbyterian | Weill Cornell Medicine

T: 212-746-6000 | www.wcinyp.com | F: 646-962-0122

(office use)

PET/MRI QUESTIONNAIRE/AUTHORIZATION

MRI is simple, safe and painless. However, because we use strong magnets during the procedure, metal objects in your body may be hazardous or cause interference. Please provide us with this important information before entering the MRI department.

Name: _____ **Date of Exam:** _____

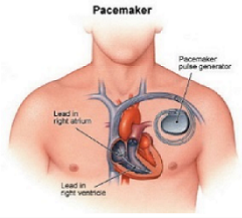
Date of Birth: _____ **Age:** ____ **Sex:** ____ **Height:** _____ **Weight:** _____

1. **Please list any oral medications you have taken today (including any medication for anxiety or claustrophobia):**

_____

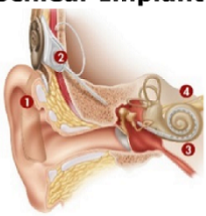
IF YOU HAVE EITHER OF THE DEVICES BELOW YOU CANNOT HAVE AN MRI.

Pacemaker /Defibrillator (ICD)



STOP

Cochlear Implant



2. **Please check YES or NO in the boxes below if you have any of the following items in your body:**

◯Yes	◯No	Pacemaker, heart monitor, defibrillator?	◯Yes	◯No	Nerve or other Stimulator?
◯Yes	◯No	Implanted drug infusion device?	◯Yes	◯No	Any metallic fragment, foreign body, or bullets?
◯Yes	◯No	Prosthesis? (eye, limb, penile, etc.) ?	◯Yes	◯No	Hearing Aid?
◯Yes	◯No	Cochlear, otologic or ear implant?	◯Yes	◯No	Tissue expander?
◯Yes	◯No	Port?	◯Yes	◯No	Catheter or feeding tube?
◯Yes	◯No	Stent, Filter, Coil?	◯Yes	◯No	Programmable Shunt?
◯Yes	◯No	Aneurysm Clips? If so, when and where were they placed?			_____
◯Yes	◯No	Artificial Heart Valve?	◯Yes	◯No	Scleral Buckle?
◯Yes	◯No	Eyelid spring or wire?	◯Yes	◯No	Tattoo, permanent makeup, or body piercing?
◯Yes	◯No	Hair extensions?			
◯Yes	◯No	**Any other metallic objects, implants, or fragments? If yes, what?**			_____

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3. Why are you having this exam?

_____

4. Have you had surgery or a biopsy? ◯ Yes ◯ No
If YES, What types and when?

_____

5. Have you had prior chemotherapy? ◯ Yes ◯ No
Are you currently on chemotherapy? ◯ Yes ◯ No
If YES, What was the date of the last cycle?

_____

6. Have you had any bone stimulating drug (Nuepogen®/ Epogen®)? ◯ Yes ◯ No
If YES, what was the last date you took this drug?

_____

7. Have you had prior radiation therapy? ◯ Yes ◯ No
If YES, please answer the following:

What body part was radiated? _____

When did radiation start? _____

When did radiation end? _____

If YES, what type of injection and where was it injected? _____

8. Are you diabetic? If YES, please answer the following: ◯ Yes ◯ No

Do you take oral medication for your diabetes? ◯ Yes ◯ No

9. Do you take insulin? ◯ Yes ◯ No

10. What is your fasting blood sugar/glucose? _____

11. Have you had a recent intramuscular injection in the past 2 weeks? ◯ Yes ◯ No
If YES, what type of injection and where was it injected? _____

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7. Do you have an allergy to Latex? ◯Yes ◯No

8. Do you have a history of kidney disease or kidney surgery? ◯Yes ◯No
   If so, are you on Dialysis? ◯Yes ◯No

9. Have you ever had an injection of MRI contrast? If YES, please answer the following: ◯Yes ◯No
   - Have you ever had hives following MRI contrast? ◯Yes ◯No
   - Have you ever had shortness of breath following MRI contrast? ◯Yes ◯No
   - Have you ever fainted/collapsed following MRI contrast? ◯Yes ◯No

10. **FEMALE PATIENTS**
    - Is there any possibility that you are pregnant? ◯Yes ◯No
    - Are you breastfeeding? ◯Yes ◯No
    - When was your last menstrual cycle? _____

Sometimes MRI requires an injection of contrast. MRI contrast (Gadolinium) is administered through a small needle placed into a vein. During the administration of MRI contrast, you may experience the sensation of the contrast being injected, which is normal and expected.

MRI contrast (Gadolinium) is quite safe, however as with all medications, there is a slight risk of an allergic reaction. The physician and staff in the MRI department are trained to respond to any emergency situation that may develop. In addition, we use the safest MRI contrast, which our physicians believe is best for you. Gadolinium has no animal or food products or derivatives, sodium chloride, glucose or preservatives. Literature on Gadolinium is available at the front desk.

I authorize Weill Cornell Imaging at NewYork-Presbyterian, its physicians and other staff to perform the prescribed examination.
I have read and understand the above information.

Signature of Patient:
(Parent or Guardian) _____ Date: _____

The Patients' Bill of Rights is available for your review.

(office use)

Front Desk Staff:_____ Signature: _____

Technologist:_____ Signature: _____

Nurse:_____ Signature: _____