 MRI Contrast Questionnaire

 If you have any queries, please e-mail: mrisafety@fortiusclinic.com

{Affix Patient Label Here}

 Patient Name

 Date of Birth

 Weight Height

|  |  |  |  |
| --- | --- | --- | --- |
| Please answer the below questions carefully, tick Yes (If applicable) or NO (If not applicable). If you answer YES to any of the following, please contact mrisafety@fortiusclinic.com | Yes | No |  Further details  |
| Have you ever had contrast media or dye injection as part of an MRI scan?  |  |  |  |
| If yes to the above, have you ever had an allergic reaction to a contrast media or dye injection? |  |  |  |
| Do you have any other known allergies? *If so please list* |  |  |  |
|  Any renal function problems or Kidney disorders? ***If yes or you are over 65 years old we will need a recent blood test result to check your kidney function.***  |  |  |  |
|  Do you suffer from reduced liver function? |  |  |  |
|  Have you recently undergone or are you due to undergo a liver transplant?  |  |  |  |
|  Do you suffer from cardiovascular disease? |  |  |  |
|  Are you asthmatic?  |  |  |  |
|  Do you suffer from Diabetes or seizure disorders? |  |  |  |
|  Do you take any medications? If yes please list.  |  |  |  |
|  Could you be pregnant?  |  |  |  |
| Are you currently breastfeeding? |  |  |  |

***Some patients undergoing an MRI scan may require an injection of intravenous dye (contrast) known as Gadolinium. After it has been injected into a vein, Gadolinium provides greater tissue contrast in the body, and provides information regarding blood flow.***

***The risk of side-effects is small, but can include minor reactions such as headache, sneezing, nausea, vomiting, hives***

***and swelling, and these symptoms usually resolve rapidly.***

***In the unlikely event of an anaphylactic reaction occurring (1 in 10 million chance) the department is fully equipped to provide the necessary intervention.***

I confirm that I have been asked the above questions and the information is correct to the best of my knowledge. I consent to the examination and the intravenous injection needed. I confirm the risks and benefits of the contrast injection have been explained to me and I consent to the injection.

Signature of Patient

Signature of Radiographer

Date

Date



**FOR STAFF USE ONLY – CANNULA AND CONTRAST RECORDS**

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| --- |
| **SITE OF CANNULATION****RT ACF                       LT ACF                  RT HAND              LT HAND         RT WRIST         LT WRIST**OTHER……………………………………………………… |
| **ROUTE: IV** | **ATTEMPTS:** | **QUANTITY:** |
| **INJECTED BY:** | **INSERTED BY:** |  |

|  |
| --- |
| **DRUG ADMINISTRATION RECORD** |
| Medicine name/ Form (BNF approved) | Dose | Route | Batch Number | Expiry Date | Administrator’s Signature | Print Name | 2nd Check Initials |
|  |  | IV |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

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| --- |
| **If you consider patient has increased risk of contrast reaction or check with radiologist**.  Checked by Radiologist:  Radiologist Outcome:  1: No contrast                          2: Contrast given, Benefits>Risk Keep Patient for 30 MINS   |
| Creatine   | EGFR   |

**I confirm that I have checked the referral for the following:**

|  |  |
| --- | --- |
| Correct Patient Identified |  |
| Areas to be scanned are compatible with clinical details |  |
| Contrast injection has been approved by radiologist |  |

Radiographer Signature Date

Counter checked by Signature Date