



**INFORMED CONSENT FOR MRI PROCEDURE**

Magnetic Resonance Imaging, or MRI, is one of the most advanced and informative diagnostic procedures available. MRI is a method of obtaining images of structures inside of your body by utilizing a large magnet and radio waves instead of x-rays or radiation to obtain images. It is completely painless and there are no known harmful side effects to the actual MRI procedure.

You will be asked to lie on the MRI table while your test is being performed. Exam times may range from as short as 15 minutes to as long as one hour, depending on the body part or number of body parts your doctor has requested to be imaged.

*In certain cases* it may be necessary for you to receive an injection of a “contrast media”. The contrast media injection allows for even more detailed images of certain structures inside of your body. This contrast media has been proven to be very safe. In a *very small* percentage of cases, headaches or nausea have been noted up to 24 hours following contrast administration. In an *even smaller* percentage of cases agitation, high or low blood pressure, stomach pain or convulsions may be noted. These reactions are *very rare*; however, these complications or other more serious complications including cardiac arrest or death must be considered as *any* injection does carry some risks.

Although the MRI procedure and contrast media injection is very safe, we believe it to be in your best interest to understand what is involved. **You are asked to sign this form to verify that you understand the indications and possible complications of this procedure. It is also important to inform the technologist of any medical conditions, including pregnancy, prior to your exam.** You will have ample opportunity to discuss any questions you may have regarding your MRI exam.

**The risks involved and the possibility of complications if pregnant during this procedure have been explained to me.**

**I acknowledge that:**

- I am pregnant**
- I am not pregnant**
- There is a possibility that I could be pregnant**

Known allergies/Medical conditions \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Your signature on this form indicates your consent for this procedure.

Patient Name \_\_\_\_\_ MRN \_\_\_\_\_

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

MRI Technologist \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Referring Physician \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_