

Date: _____/_____/_____ Patient: _____

BCS Schedule: _____ MR
number: _____

1. Do you have a cardiac pacemaker or defibrillator?
Yes _____ No _____
2. Do you have an aneurysm clip in your brain?
Yes _____ No _____
3. Have you ever worked with metal or do you have any metal fragments in your eyes? History of eye trauma involved with metal?
Yes _____ No _____
4. Have you had any surgery **in the past eight weeks**, including dental work?
Yes _____ No _____
5. Do you have a vascular stent or access port (for example: chemotherapy)?
Yes _____ No _____
6. Do you have Harrington rods?
Yes _____ No _____
7. Do you have any kidney/renal problems?*
8. Are you 55 years of age or over?*
9. Have you ever been given intravenous (IV) contrast for a radiology study? (IVP, CT scan, Angiogram, etc)
Yes _____ No _____
Did you experience problems during or after the exam?
Yes _____ No _____
If they have had problems with prior IV contrast: **chart to MR technologist.**
10. Are you allergic to iodine or gadolinium?
Yes _____ No _____
11. Do you have any foreign object in your body? Internal medical device?
Yes _____ No _____
If yes, please complete and return the MR Device Safety Form to BCS. The device's safety must be confirmed and cleared by BCS M.D. prior to scheduling.

If 'yes' to any of the questions, attach this form to the patient's chart and forward chart to MR technologists

*** Please fax (678-732-1129) or mail this completed form to Breast Care Specialists, LLC, with attention to MRI Scheduling.**