Wise Health System

Affiliated with, but not controlled by, Baylor Scott & White Health or its subsidiaries or community medical centers

2000 S. FM 51 | Decatur, TX 76234 | 940-627-5921 | WiseHealthSystem.com

MRI Contrast Screening Form

Name:_____**Date:**_____

Referring Physician:_____

Date of Birth: _____ **Age:** _____ **Patient Weight:** _____

BUN: _____ **Creatinine Level:** _____ **GFR**: _____

No labs available ☐ **Source:**_____ **Date/time of labs**_____

Have you ever had contrast material for kidney x-ray, CT, MRI or other imaging study? ☐ Yes ☐ No

Do you have any Known allergies? ☐ Yes ☐ No If yes, please list:_____

Are you breastfeeding?	☐ Yes	☐ No
Do you have asthma?	☐ Yes	☐ No
Do you have diabetes?	☐ Yes	☐ No
Dialysis/Renal Failure/Insufficiency?	☐ Yes	☐ No
Do you have hypertension?	☐ Yes	☐ No
Do you have Liver Disease?	☐ Yes	☐ No
Do you have sickle cell anemia?	☐ Yes	☐ No
Have you had a history of kidney disease?	☐ Yes	☐ No
Do you have multiple Myeloma?	☐ Yes	☐ No

Information obtained by ☐ **Patient** ☐ **Medical Record** ☐ **Family**

Patient Signature _____

Venipuncture Information For Office Use Only:

Date: _____ Time:_____ Venipuncture Site: (circle) RT LT _____

Needle size: _____ Contrast Type (circle) Optimark Gadavist Amount: _____Ml

Lot#_____ Expiration date:_____ Injected by:_____

Patient/Family education ☐ Yes ☐ No

Technologist Signature_____ Date:_____

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