YOUNGSTOWN
ORTHOPAEDIC
ASSOCIATES

1499 Boardman-Canfield Road
Boardman, OH 44512

6470 Tippecanoe Road
Canfield, OH 44406

330.758.0577 (phone)
330.758.0466 (fax)
www.youngstownortho.com

MRI Contrast Screening Form

Patient Name:_______________________________ Date:____________________

Referring Physician ____

Date of Birth: ________________ Age:__________ Patient weight:___________

BUN_________ Creatinine Level ____________ GFR/Clearance______________

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

Allergic to seafood or shellfish? ☐Yes ☐No

If yes, did you have any discomfort or allergic reaction? ☐Yes ☐No

What type of reaction did you have?____________________________________

Do you have any known allergies? ☐Yes ☐No If yes, _________________________

Do you have heart disease or vascular disease? ☐Yes ☐No

Are you breastfeeding? ☐Yes ☐No

Do you have asthma? ☐Yes ☐No

Do you have diabetes? ☐Yes ☐No

Dialysis/Renal Failure/Insufficiency ☐Yes ☐No

Renal Dialysis ☐ Yes ☐No

What type of diabetic medication are you taking?____________________________

Do you take generic metformin (Glucophage, Avandamet, Glocovance, or Metaglip)?

____

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

Venipuncture Information:

Date:_________ Time:_________ Venipuncture site: ______________________

Needle type: _______ Contrast type: Magnevist Contrast Amount: ______ml

Lot# ___________ Injected by:________________

Patient / Family education: ☐Yes ☐No

Technologist Signature: ____

02.01.10