



**San Luis Diagnostic Center**  
 1100 Monterey Street, Suite 210  
 San Luis Obispo, California 93401

(805) 542-9700 • Fax (805) 542-0584  
 www.SLDCinfo.com

PATIENT: \_\_\_\_\_  
 Last Name, First Name Middle Initial

WEIGHT: \_\_\_\_\_

## CONSENT FOR MRI OF THE SPINE

**Please complete this form to the best of your ability. If you do not know the answer, please leave it blank. If our doctor deems it necessary to get this information we will contact you.**

The following may interfere with an MRI exam, and some could be hazardous to your health.

Do you have (a/an/any)

Heart Pacemaker/Defibrillator?	Yes	No	Stent?	Yes	No
Aneurysm clips from brain surgery?	Yes	No	Cochlear Implant(s)?	Yes	No
Kidney Disease or Kidney problems?	Yes	No	Artificial Joint(s)?	Yes	No
Surgical Clips?	Yes	No	Harrington Rods?	Yes	No
Artificial heart valve(s)?	Yes	No	Wire Sutures?	Yes	No
Insulin Pump?	Yes	No	Dentures?	Yes	No
Hearing Aid(s)?	Yes	No	Are you pregnant or nursing?	Yes	No
Possibility of metal fragments in your eyes?	Yes	No	Mechanical device worn externally or implanted internally?	Yes	No
Cosmetic piercings or implants? (Other than dental implants)	Yes	No			

To complete your MRI exam, we may need to administer a special MR contrast agent. The contrast agent is given through a needle placed into your vein. This contrast is considered very safe. Infrequently, a patient will have a mild reaction to the contrast. The radiologist and the technologists at San Luis Diagnostic Center are trained to treat such reactions. To date, only a very few serious reactions to the agent have been reported in the United States.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient:  Self  Parent or guardian of minor patient  Guardian or conservator of patient

Please remove the following items before having your MRI examination.  
 Secure them and all your valuables in your dressing room locker.

<b>Hearing aids</b>	<b>Wallet/Credit cards</b>	<b>Wig</b>	<b>Dentures</b>
<b>Jewelry (except rings)</b>	<b>Keys</b>	<b>Hairpins</b>	<b>Safety pins</b>

# (Continued on Back)



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PATIENT: \_\_\_\_\_

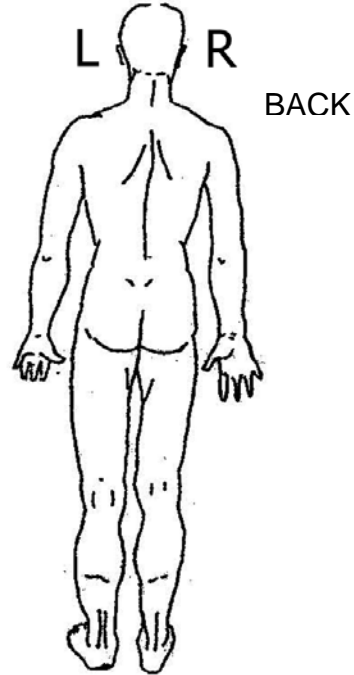
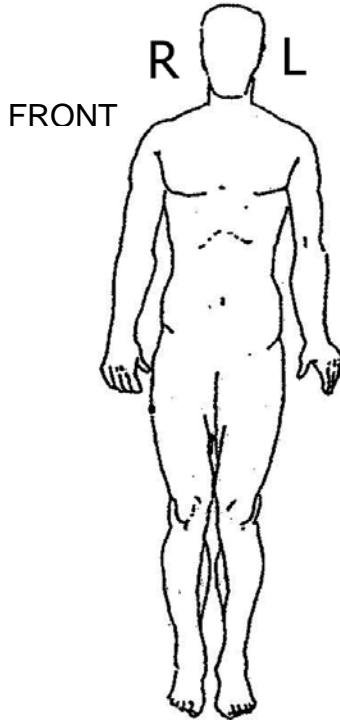
Last Name

First Name

DATE OF SERVICE: \_\_\_\_\_

## MRI OF THE SPINE

**This form will be used to aid the radiologist in interpretation of this study only.**  
Please indicate on the diagram below, where you are experiencing pain.



- **Generally, is your pain worse on the** (Please circle):  
Mid-spine / Right side / Left side OR Equal (both sides).

- **What sensations are you experiencing?** (e.g. aching, tingling, burning, shooting pains, etc.)

\_\_\_\_\_

**How long have you had these sensations:** \_\_\_\_\_

**Did you have a specific injury?**  Yes  No **If yes, when?** \_\_\_\_\_

- **Are you having any bowel and/or bladder problems?**  Yes  No

- **Have you ever had cancer?**  Yes  No

If yes, what type? \_\_\_\_\_

Have you had Radiation Therapy?  yes  no \_\_\_\_\_

Have you had Chemotherapy?  yes  no \_\_\_\_\_

- **Have you ever had surgery on your spine?**  yes  no

If yes, what area? When was it performed? \_\_\_\_\_

\_\_\_\_\_