



Department of Diagnostic Imaging
MRI Contrast Screening Form

LAST NAME	(FIRST)
MRN	VISIT NUMBER
DATE OF BIRTH DD-MM-YYYY	SEX
ADDRESS	

Type of MRI scan: _____

Date of scan: _____ Time: _____

Important information:

MRI scans may require the administration of a gadolinium-based contrast agent to enhance diagnosis. The contrast agents used at SickKids are Health Canada approved and considered to be safe. Administration is through an intravenous (IV) site. Occasional and temporary side effects include nausea, headache and tingling at the injection site. Rarely a severe allergic reaction such as anaphylaxis may occur and require immediate medical treatment. Some patients have been found to retain a small amount of gadolinium within their bodies or brain. To date, no known ill effect has been observed. Administration of a gadolinium-based contrast agent is at the discretion of the Radiologist.

Please answer:

Patient is under 12 months of age?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other relevant information, including current medications:
Type 1 diabetes?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Transplant? (bone marrow, kidney, other organ)	<input type="checkbox"/> Yes <input type="checkbox"/> No	
History of kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Ever been seen by a kidney specialist?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
History of liver disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
History of high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Currently receiving chemotherapy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Previous MRI with contrast?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contrast reaction? <input type="checkbox"/> Yes <input type="checkbox"/> No
Allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, to what is the patient allergic?:
Asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

I attest that the above information is correct to the best of my knowledge. I have read and do understand the contents of this form. I have had the opportunity to ask questions about the information given.

Patient Parent Caregiver Other: _____

Patient / Parent / Caregiver signature: _____ Date: _____

Healthcare provider signature: _____ Date: _____

Interpreter name: _____ Interpreter phone: _____

<p>MRI Department use only:</p> <p>Renal risk factors identified? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>If yes: note patient's creatinine: _____</p> <p>Date collected: _____</p> <p>Patient height (cm): _____</p> <p>eGFR: _____</p>
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