



BREAST MRI INFORMATION SHEET

Patients with pacemakers can NOT have MRI / MRA

Name _____ Referring MD _____ Date _____
 Date of Birth _____ Age _____ Height _____ Weight _____
 Contact numbers: Home _____ Cell _____ Work _____

MRI SCREENING INFORMATION *Do you have any of the following devices?*

- | | |
|---|---|
| <input type="checkbox"/> Pacemaker or defibrillator | <input type="checkbox"/> Hearing aid |
| <input type="checkbox"/> Coronary stent | <input type="checkbox"/> Cochlear or Stapedial Implant |
| <input type="checkbox"/> Cardiac valve replacement | <input type="checkbox"/> Pessary (bladder ring) |
| <input type="checkbox"/> Brain aneurysm clip | <input type="checkbox"/> Electrical Stimulation Device |
| <input type="checkbox"/> Breast tissue expander | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Medication Patch
(including a nicotine patch) | <input type="checkbox"/> Shrapnel or Metal Injuries (bullet, metal slivers) |

CONSENT FOR INTRAVENOUS CONTRAST

Your Doctor has ordered a Breast MRI which requires the administration of intravenous contrast (unless the exam is solely for the evaluation of implants). The substance we use is called "gadolinium", a safe, organic substance which will be excreted by your kidneys within 24 hours. Although this contrast has been shown to be extremely safe, you **MUST** inform us of any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Kidney problems including dialysis | <input type="checkbox"/> Sickle cell anemia or sickle cell trait |
| <input type="checkbox"/> Pregnancy or breast feeding | <input type="checkbox"/> Asthma or respiratory disorders |

It is unusual to have any adverse reactions, but the most common noted were; headaches and/or an unusual taste in the mouth.

I have read the above and give my consent for intravenous contrast: X _____

Patient Signature

BREAST HISTORY *answer to the best of your ability*

Do you still menstruate? Yes No If so, what was the start date of your last period? _____
 Are you taking hormone replacement therapy? Yes No
 Have you had Breast cancer? Yes No Ovarian cancer? Yes No Do you have BRCA gene? Yes No
 Has anyone in your family had:
 Breast cancer? _____ Who? _____ Age _____
 Ovarian cancer? _____ Who? _____
 Last mammogram Nassau Radiologic Group Other facility: Name of facility _____ year _____

Clinical Concerns: *check all that apply*

<input type="checkbox"/> You or doctor feels a lump	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Nipple discharge	<input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> Breast pain	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Recent breast injury	<input type="checkbox"/> Right <input type="checkbox"/> Left
<input type="checkbox"/> Breast skin changes	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Abnormal mammo/sonogram	<input type="checkbox"/> Right <input type="checkbox"/> Left

Prior Breast Procedures: *check all that apply*

<input type="checkbox"/> Fine Needle or Cyst Aspiration	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Benign <input type="checkbox"/> Malignant	Year _____
<input type="checkbox"/> Needle or Core Biopsy	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Benign <input type="checkbox"/> Malignant	Year _____
<input type="checkbox"/> Surgical lumpectomy or biopsy/excision	<input type="checkbox"/> Right <input type="checkbox"/> Left	<input type="checkbox"/> Benign <input type="checkbox"/> Malignant	Year _____
<input type="checkbox"/> Mastectomy	If you had reconstruction, what type?	<input type="checkbox"/> Flap reconstruction	<input type="checkbox"/> Implant <input type="checkbox"/> Tissue Expander
<input type="checkbox"/> Breast Plastic Surgery	If so, what type?	<input type="checkbox"/> Lift <input type="checkbox"/> Reduction	<input type="checkbox"/> Implants (silicone or saline)

Other Treatments: *check all that apply*

Radiation treatment to breast or chest.... Last Treatment Date _____
 Chemotherapy.... Last Treatment Date _____
 Any medication for prevention of breast cancer? _____

TECHNOLOGIST WORK SHEET

REASON FOR BREAST MRI EXAM

- Presurgical evaluation (recently diagnosed breast cancer)
- High risk screening
 - personal history of treated breast cancer
 - family history of breast cancer
 - history of high risk lesion (ADH, ALH, LCIS)
 - genetic predisposition (BRCA+)
- Clinical concern (lump, breast pain, nipple discharge, skin changes)
- Problem solving (mammographic or sonographic abnormality)
- Response to chemotherapy
- Short term follow up to prior MRI/MRI bx.
- Rule out implant rupture

