



MEDICAL IMAGING OF MANHATTAN, LLC
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What is a breast MRI?

A breast MRI is a test which uses a powerful magnetic field (not radiation) to make images of the inside of the breasts.

How should I prepare for my breast MRI?

- **Please send all related test reports and images (like previous mammograms, ultrasounds, etc.) to Medical Imaging of Manhattan prior to the MRI. We will return them when the doctors complete the report for the breast MRI.**
- You can take your regular medicine on the day of the test.
- Please leave jewelry and personal items at home. You may use a locker for your belongings.
- You will fill out a medical history form and a safety questionnaire that asks if you have any type of metal in your body.
- You will need to change into an exam gown.

What is the exam like?

- The MRI machine is a tunnel that is open at both ends.
- MRI tests are not painful. In fact, you won't feel anything at all.
- Prior to starting the exam an intravenous catheter (IV) will be placed in your arm. Once the exam begins, the technologist will connect the IV to a machine that injects the contrast material called gadolinium for the MRI (it is not radioactive).
- You will lie face down on a cushioned device with your breasts hanging through the openings.
- The technologist will give you earplugs to protect your hearing during the exam because while the MRI machine is taking the images, there are loud thumping sounds. These are normal sounds – *please don't worry.*
- The scanner bed will move into the tunnel and the technologist and assistants will leave the room. The technologist will communicate with you through a microphone to give you instructions.
- You will be staying in the tunnel during the entire test. It is important to hold very still while the machine is taking pictures.
- The entire test should take close to 45 minutes.
- After your MRI, you may go back to your usual activities.

How do I get my results?

Our Board Certified Radiologists interpret the results and send a detailed report to the doctor who ordered the test, usually within 48-72 hours from the date of the exam. At the same time, one of our doctors will call you to inform you of your results - please give us the best telephone number to reach you.

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MRI SCREENING FORM

PATIENT NAME: _____

DATE: ____ / ____ / ____

DATE OF APPOINTMENT: ____ / ____ / ____

DATE OF BIRTH: ____ / ____ / ____

REFERRING PHYSICIAN: _____

PHONE #: _____

Have you had a prior MRI examination?

YES NO

Date of prior MRI: ____ / ____ / ____

Do you have a history of a reaction to Gadolinium, the contrast medium or dye used for an MRI examination?

YES NO

Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind?

YES NO

Do you have a history of :

Kidney disease

YES

NO

Anemia

YES

NO

Diabetes

YES

NO

Seizures

YES

NO

Asthma

YES

NO

Severe liver disease

YES

NO

Hypertension

YES

NO

or liver transplant

If yes, please explain: _____

Are you allergic to any medications?

YES NO

If yes, please list: _____

For female patients:

1. Date of last menstrual period : ____ / ____ / ____

Postmenopausal?

YES

NO

2. Are you pregnant or experiencing a late menstrual period?

YES

NO

3. Are you taking oral contraceptives or receiving hormonal therapy?

YES

NO

4. Are you currently breastfeeding?

YES

NO

5. Why is this exam being done? *Please circle one.*

- routine screening
- recently diagnosed breast cancer
- a problem that needs to be evaluated
- evaluation of breast implants

6. Have you had breast plastic surgery performed?

YES

NO

If yes, which kind? *Please circle one.*

- saline implants
- silicone implants
- reductions
- mastopexy (lift)

Have you had an injury to the eye involving a metallic object or fragment

(e.g., metallic sliver, shavings, foreign body, etc.)?

YES

NO

Have you ever been injured by a metallic object or foreign body, (e.g., BB, shrapnel, etc.)?

YES

NO

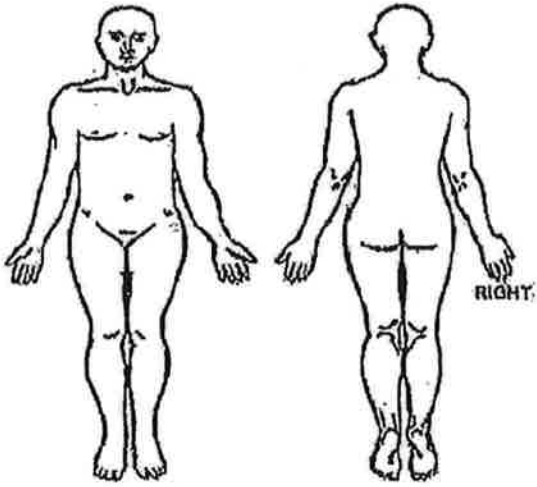
WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. *Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.*

See reverse

Do you have any of the following?

- | | | |
|--|------------------------------|-----------------------------|
| Pacemaker | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Implanted cardiac defibrillator | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cardiac or vascular shunt | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Heart valve prosthesis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Retinal tack | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Aneurysm clip | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Electronic implant or device | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Magnetically activated implant or device | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Neurostimulation system | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Spinal cord stimulator | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Internal electrodes or wires | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bone growth/bone fusion stimulator | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cochlear, otologic or other ear implant | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Insulin or other infusion pump | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Implanted drug infusion device | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Any type of prosthesis (eye, penile, etc.) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Heart valve prosthesis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Eyelid spring or wire | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Artificial or prosthetic limb | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Metallic stent, filter or coil | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Shunt (spinal or intraventricular) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Vascular access port and/or catheter | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Radiation seeds or implants | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Swan-Ganz or thermodilution catheter | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Medication patch (Nicotine, Nitroglycerine) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Any metallic fragment or foreign body | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Wire mesh implant | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Tissue expander (e.g., breast) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Surgical staples, clips or metallic sutures | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Joint replacement (hip, knee, etc.) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bone/joint pin, screw, nail, wire, plate, etc. | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| IUD, diaphragm, or pessary | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Dentures or partial plates | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Body piercing jewelry | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hearing aid | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| <i>(Remove before entering MR system room)</i> | | |
| Other implant _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Breathing problem or motion disorder | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Claustrophobia | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Please mark the figure(s) below with the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove **all** metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, and clothing with metallic threads.

NOTE: You may be advised to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

SCREENED BY: _____ DATE: / /

I verify that the answers I have provided to questions on this form are correct and understand that withholding information or inaccurate information may adversely affect the interpretation of this exam.

Patients Signature:

Date:



MEDICAL IMAGING OF MANHATTAN, LLC

Account # _____

Tech: _____

Date: _____

Pelvic/Transvaginal Sonography Questionnaire

Name: _____

Age: _____

Date of Birth: _____

Date of Last Menstrual Period: _____

Are you Pregnant? (Please circle) No/Yes

If Yes, how many weeks? _____

When?

Where?

Most recent Pelvic/TV Exam _____

Reason for today's exam: (Routine/Follow-up/Medical problem or Complaint):

List previous surgeries: _____

List Current Medications (including hormones, birth control, etc):

Is there a family history of ovarian cancer? (Please circle) No/Yes If yes, please explain

IF YOU HAVE BROUGHT PREVIOUS FILMS OR REPORTS WITH YOU, PLEASE GIVE THEM TO THE RECEPTIONIST BEFORE YOUR EXAM.



Patient Name _____

Registration # _____

() _____

() _____

() _____

Primary Phone Mobile
 Work
 Home

Secondary Phone Mobile
 Work
 Home

Tertiary Phone Mobile
 Work
 Home

Email Address: (Please Print Neatly) _____

Would you prefer if we send you appointment reminders by email?

Yes No

How would you like our staff to address you when being called from the waiting area? _____

I attest that within the last 30 months, I have seen and am a patient of the physician listed below, to whom I would like you to send today's radiology report.

Patient Signature

1) (Required)

Name

Telephone # Fax #

- Mammo
- Sono
- MRI
- Biopsy
- Bone Densitometry
- Other

Address

2) (Only if necessary)

Name

Telephone # Fax #

- Mammo
- Sono
- MRI
- Biopsy
- Bone Densitometry
- Other

Address

3) (Only if necessary)

Name

Telephone # Fax #

- Mammo
- Sono
- MRI
- Biopsy
- Bone Densitometry
- Other

Address

I authorize the release of my medical reports to my insurance carrier and any of my physicians, if requested by them.

I further acknowledge that a copy of rights under HIPAA have been supplied to me.

Patient or Authorized Signature

Date

Please see reverse

Dear Patient,

Please be advised that Medical Imaging of Manhattan does not participate with any medical insurance plans and has opted out of Medicare.

If you are here today for a Screening Mammogram and your last Mammogram was less than one year ago, please be advised that your insurance carrier **might not** reimburse you for your mammogram today.

If you choose **not** to have consultation with a radiologist today, the standard images will be taken by the technologist, and you will receive your results in the mail within 5 business days.

Once you have paid for your visit in full, you will be given a receipt to submit to your insurance carrier for reimbursement. No claim can be submitted by you or this office to Medicare.

Please keep in mind that depending upon the type of coverage you have, your insurance carrier may or may not acknowledge the claim fully or at all. Although we will try to help you, Medical Imaging of Manhattan is not responsible for any reimbursement or denial you receive.

- I **do** have Medicare insurance.
- I **do not** have Medicare insurance.

I understand and accept the terms described above:

Signature

Print Name

Date



MEDICAL IMAGING OF MANHATTAN, LLC

DATE: _____

NAME: _____

ACCT# _____

I authorize Medical Imaging of Manhattan, LLC to apply the fee of \$ _____ to my MasterCard/Visa/Discover/AMEX.

You can pay with your VISA/MasterCard/Discover/AMEX

If you wish to pay with your VISA, MasterCard, Discover, or AMEX, please complete the following:

Card # _____

Exp. Date _____ 3 Digit Security Code _____

VISA MasterCard Discover AMEX (circle one)

Signature _____

Fill out & mail, or call our office.

Thank you.