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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.

635 Madison Avenue • 16th Floor • New York • New York 10022 • (212) 794-2500 • Fax (212) 879-3846 • www.mimrad.com

MEDICAL IMAGING OF MANHATTAN, LLC

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 or liver transplant	☐YES	☐NO
Hypertension	☐YES	☐NO			

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

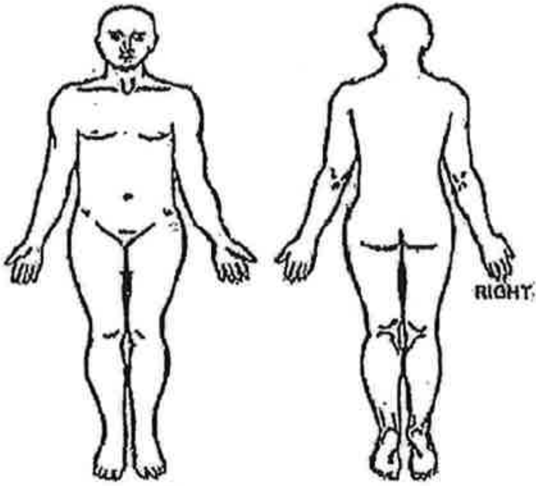
WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). <u>Do not enter</u> the MR system room or MR environment if you have any question or concern regarding an implant, device, or 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	□YES	□NO
Implanted cardiac defibrillator	□YES	□NO
Cardiac or vascular shunt	□YES	□NO
Heart valve prosthesis	□YES	□NO
Retinal tack	□YES	□NO
Aneurysm clip	□YES	□NO
Electronic implant or device	□YES	□NO
Magnetically activated implant or device	□YES	□NO
Neurostimulation system	□YES	□NO
Spinal cord stimulator	□YES	□NO
Internal electrodes or wires	□YES	□NO
Bone growth/bone fusion stimulator	□YES	□NO
Cochlear, otologic or other ear implant	□YES	□NO
Insulin or other infusion pump	□YES	□NO
Implanted drug infusion device	□YES	□NO
Any type of prosthesis (eye, penile, etc.)	□YES	□NO
Heart valve prosthesis	□YES	□NO
Eyelid spring or wire	□YES	□NO
Artificial or prosthetic limb	□YES	□NO
Metallic stent, filter or coil	□YES	□NO
Shunt (spinal or intraventricular)	□YES	□NO
Vascular access port and/or catheter	□YES	□NO
Radiation seeds or implants	□YES	□NO
Swan-Ganz or thermodilution catheter	□YES	□NO
Medication patch (Nicotine, Nitroglycerine)	□YES	□NO
Any metallic fragment or foreign body	□YES	□NO
Wire mesh implant	□YES	□NO
Tissue expander (e.g., breast)	□YES	□NO
Surgical staples, clips or metallic sutures	□YES	□NO
Joint replacement (hip, knee, etc.)	□YES	□NO
Bone/joint pin, screw, nail, wire, plate, etc.	□YES	□NO
IUD, diaphragm, or pessary	□YES	□NO
Dentures or partial plates	□YES	□NO
Body piercing jewelry	□YES	□NO
Hearing aid	□YES	□NO
(Remove before entering MR system room)		
Other implant____________________	□YES	□NO
Breathing problem or motion disorder	□YES	□NO
Claustrophobia	□YES	□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 <u>all</u> 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?___________

Most recent Pelvic/TV Exam When? _____________ Where? ____________________

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 # ______

Address ______________________

☐ Mammo
☐ Sono
☐ MRI
☐ Biopsy
☐ Bone Densitometry
☐ Other

2) (Only if necessary)

Name ______________________

Telephone # ______ Fax # ______

Address ______________________

☐ Mammo
☐ Sono
☐ MRI
☐ Biopsy
☐ Bone Densitometry
☐ Other

3) (Only if necessary)

Name ______________________

Telephone # ______ Fax # ______

Address ______________________

☐ Mammo
☐ Sono
☐ MRI
☐ Biopsy
☐ Bone Densitometry
☐ Other

☐ 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**

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.

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