Lake of the Woods District Hospital

MRI PATIENT APPOINTMENT PREPARATION SHEET
ENTEROGRAPHY

Welcome, to perform your exam in a timely manner, kindly follow the patient instructions below:

WEEKS or DAYS preparing before appointment:

- Due to the weight capacity of the imaging equipment, please contact Diagnostic Imaging (807) 468-9861 ext. 2201 if your weight is >450lbs.
- Arrange childcare, for safety reasons children are not permitted in the examination room and cannot be left unattended.
- Arrange for a support person to accompany you if required.
- ***DIABETIC*** patients – Glucose sensors may need to be removed for the examination, plan accordingly with a replacement and/or coordinate with date of scheduled sensor removal.
- If you are pregnant or think you may be pregnant, please notify the department ahead of time as your exam date may change based on these circumstances.
- Complete the *Magnetic Resonance Imaging (MRI) Screening Form* (attached).

HOURS preparing before appointment:

- **ARRIVE** and **REGISTER** at Diagnostic Imaging **90 minutes prior** to your appointment. There is considerable preparation beforehand that is a requirement for this examination. Failure to arrive at the specified time will result in cancellation.
- You will go through a screening process, exam preparation, and an MRI technologist will explain the procedure and answer any questions pertaining to the examination.
- Your appointment will take between 15-90 minutes, not including waiting time, plan accordingly.
- **Follow fasting instructions: Nothing to eat or drink 6 hours before scheduled appointment time.**
- Remove all or as much jewelry and body piercings as possible.

BRING to your appointment:

- Payment for parking
- Healthcare card and valid picture identification
- A legal guardian should accompany all patients under the age of 18 and those who do not have the capacity to provide consent.
- Your eyeglasses, hearing aids, and mobility devices.
- ***DIABETIC*** patients - bring your medications/supplies as needed.
- Implant Cards pertaining to devices implanted in your body.
- Completed *Magnetic Resonance Imaging (MRI) Screening Form*

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AT the appointment:

- You may be asked to change into a hospital gown.
- 45 min prior to your exam you will be given an oral contrast agent, this contrast will distend your bowel so we can image properly. You will be asked to consume 1400 ml of contrast agent.
- You will have an intravenous injection of an antispasmodic agent and MRI contrast therefore you will have an i.v. inserted into your arm.

AFTER the appointment:

- The oral contrast agent you consumed may cause loose stools, therefore please consider your availability to a washroom afterwards.

To ***RESCHEDULE*** or ***CANCEL*** your appointment please call Diagnostic Imaging (807) 468-9861 ext.2201 or if you have any questions pertaining to your examination.

Thank you and we look forward to seeing you soon.

Lake of the Woods District Hospital

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
Health Card #	Version
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown	

MAGNETIC RESONANCE IMAGING (MRI) SCREENING FORM

The following items may interfere with your Magnetic Resonance Imaging examination and some can potentially be **hazardous**.

Do you have drug ***allergies?*** ☐ No ☐ Yes *(please list them):*

Patient ***Height*** in/cm	Patient ***Weight*** lb./kg

Have you had MRI IV contrast before? ☐ No ☐ Yes ► Did you have a reaction? ☐ No ☐ Yes

Are you on dialysis? ☐ No ☐ Yes Are you Claustrophobic? ☐ No ☐ Yes

Please indicate if you have the following	No	Yes	Please indicate if you have the following	No	Yes
Cardiac pacemaker			Eye prosthesis		
Implanted cardiac defibrillator *(ICD)*			Eyelid spring or wire		
Brain Aneurysm clip(s) or coil (s)			Penile prosthesis		
Electronic/Magnetic implant or device			IV access port, IVAD, PICC Line		
Implanted drug infusion device *(e.g., insulin, baclofen, chemo, pain meds)*			Intrauterine device *(IUD)*, diaphragm, pessary		
Endoscopy Clips *(e.g., Resolution Clip)*			Artificial joint/limb *(e.g., prosthesis, replacement)*		
Cardiac Pacing Leads/Wires			Bone/Joint pin, screw, nail, wire, plate		
Bone Growth/Neurostimulator			Glucose Monitoring Device *(sensor)*		
Coils, Filters, or Stents			Medication patch *(hormone, nicotine.)*		
Shunt *(renal, brain, heart, spine)*			Hearing aid		
Middle Ear Implants *(cochlea, stapes)*			Dentures or partial plates		
Swan-Ganz or thermodilution catheter			Tattoo or permanent makeup		
Heart valve prosthesis			Jewelry you cannot remove		
Tissue expanders (e.g., breast)			Have you ever had metal in your eyes?		
Surgical staples, clips, wire sutures			Was the metal removed by a doctor?		
Silver impregnated dressing			Are you pregnant?		
Shrapnel, bullet, or BB			Date of last menstrual period:		

Have you ever had any surgical procedures or operations? ☐ No ☐ Yes *(list all)*	Year
Type	
Type	
Type	
Type	
Type	

I have answered the above questions to the best of my ability. The MRI examination has been explained to me, and I have had my questions answered to my satisfaction.

Signature of Patient or Guardian	Date *(dd-Mon-yyyy)*
Witness/Technologist Name *(print)*	Witness/Technologist Signature

Lake of the Woods District Hospital

MAGNETIC RESONANCE IMAGING (MRI) CONTRAST FORM

Last Name *(Legal)*	First Name *(Legal)*
Preferred Name ☐ Last ☐ First	DOB *(dd-Mon-yyyy)*
Health Card #	Version
Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown	

MRI Contrast Information - GADOLINIUM

You are having Magnetic Resonance Imaging (MRI) and it is important that you be informed about the procedure. You may require an injection of "dye" or contrast. The contrast will be given by an injection into a vein in your hand, arm or leg. The contrast makes certain diseases and important body structures more visible on MRI images.

Most people have no ill effects from the contrast. Sometimes mild reactions do occur but pass without treatment or respond quickly to medication. The risks or reactions associated with the contrast injection may include *(but are not limited to)* a "sweet" taste in your mouth, headache, nausea. Very rarely you may experience dizziness, vomiting, or an allergic reaction *(hives, watery eyes)*.

Severe reactions can rarely occur that require medical treatment. These may include difficulty breathing, shock or heart failure.

If you feel any discomfort or experience any of these symptoms, please inform the nurse or the technologists performing your exam. The physicians caring for you are aware of these risks and have determined that the benefit of the diagnostic information outweighs the low risk.

Should you have any of these symptoms after your test, please contact your family physician immediately.

I authorize the radiologist and/or designated healthcare professional to perform the procedure with the administration of MRI contrast media as deemed necessary for the examination.

All potential risks of the contrast injection have been explained to me.

Signature of Patient or Guardian	Date *(dd-Mon-yyyy)*
Witness/Technologist Name *(print)*	Witness/Technologist Signature

MRI Staff to fill out if patient is on renal dialysis		
Creatinine Level	GFR	Date Collected *(dd-Mon-yyyy)*
Checked with Radiologist		

Magnetic Resonance Imaging Use Only		
Contrast injected by *(print)*		Time of injection *(hh:mm)*
Contrast type	Amount	
Site of administration	Contrast Lot #	Expiry Date *(dd-Mon-yyyy)*