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UVM MRI CENTER FOR BIOMEDICAL IMAGING

The UNIVERSITY of VERMONT COLLEGE OF MEDICINE

Phone#: 802-847-4117
Fax#: 802-847-8760

MRN#:

PATIENT NAME:

DOB:

DATE AND TIME EXAM IS SCHEDULED MM / DD / YY	RESEARCH COORDINATOR/CONTACT NUMBER: (please print)		
PRINCIPAL INVESTIGATOR	STUDY NAME:		
STUDY WEEK:	CHRMS#:	960#	Height cm / Weight kg / LMP MM / DD / YY
SITE IDENTIFICATION (ID) NUMBER (If applicable)	SUBJECT IDENTIFICATION NUMBER(If applicable)		FUNDING SOURCE: (Please indicate if unfunded pilot study)
STUDY DESCRIPTION:			

THIS AREA MUST BE COMPLETED FOR CONTRAST ENHANCED STUDIES

FOR IV Contrast Enhanced Studies

Renal Insufficiency: ☐ Yes ☐ No	Diabetes: ☐ Yes ☐ No	Does this Protocol Require IV Contrast: ☐ Yes ☐ No
Kidney Disease: ☐ Yes ☐ No	High Blood Pressure: ☐ Yes ☐ No	Prior Allergic Reaction to IV Contrast: ☐ Yes ☐ No
Any Relevant, Recent or Prior Surgery ☐ Yes ☐ No Date of prior Surgery: _____	Liver Disease: ☐ Yes ☐ No	Creatinine:_____ Date:_____ (for contrast exams only)

MANDATORY INFORMATION-MRI SCAN (This Area Must be Completed)

Cardiac Pacemaker: ☐ Yes ☐ No	Cerebral Aneurysm Clip: ☐ Yes ☐ No	Known Metal in Body to Include Metallic IUD: ☐ Yes ☐ No
Swan Ganz Catheter ☐ Yes ☐ No	Nerve Stimulation Device: ☐ Yes ☐ No	Intraventricular Shunt: ☐ Yes ☐ No
Claustrophobia: ☐ Yes ☐ No	Cochlear/Middle Ear Implant: ☐ Yes ☐ No	Implanted Pumps or Stents: ☐ Yes ☐ No
Is Oral Sedation Needed: ☐ Yes ☐ No	Transdermal Patches: ☐ Yes ☐ No	Pregnant: ☐ Yes ☐ No

Metal worker or eye injury w/Metal: ☐ Yes ☐ No If so, have orbit films been done: ☐ Yes ☐ No

Permission to consent subject for MRI Center Databank Protocol ☐ Yes ☐ No

*If multi-center pharmaceutical trial, please include MRI transmittal form.

STUDY

☐	MR Brain	☐		☐	
☐	MR Spine	☐		☐	
☐	MR Abdomen	☐		☐	
☐	MR Extremity	☐		☐	
☐	Other:	☐		☐	

NOTES

Notes: