



MRI Contrast / NSF Worksheet

Patient Name: _____
Weight: _____

Gender: [] Male [] Female Age _____
Race: [] African American [] Non-African American

Medical History to be completed by patient:

If yes, please explain here:

- 1. Are you on dialysis? [] Yes [] No
2. Do you have a history of kidney tumor or cancer? [] Yes [] No
3. Do you have a history of kidney infection or urinary problem? [] Yes [] No
4. Do you have only one kidney or had a kidney transplant? [] Yes [] No
5. Do you have diabetes or take diabetes medicine? [] Yes [] No
6. Do you have high blood pressure that requires medication? [] Yes [] No

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient Signature

Print Name

Date

This section to be completed by the Technologist, RN, or Radiologist:

If the patient answered "yes" to any of the questions listed above, and/or is 70 years of age or older, a serum creatinine test may be performed at the discretion of the supervising radiologist to calculate a GFR prior to contrast administration.

Examination ordered: _____ Referring MD: _____

Diagnosis: _____

Gender: [] M [] F Race: [] African American [] Non-African American Serum Creatinine _____ GFR _____

GFR calculated by (signature of Technologist or RN): _____ Date: _____

Contrast Brand Name: _____ Contrast Dosage: _____ ml

Contrast consent form signed by the patient? [] Yes [] No

For GFR results below 40 ml/min, signature of the radiologist in charge is required to administer contrast.

Radiologist's signature: _____ Date: _____

Technologists Notes:

Three horizontal lines for handwritten notes.