You are scheduled for a MRI of the Prostate on ______________ at ______________.

Please report to 1C in Duchossois Center For Advanced Medicine (DCAM) 30 minutes before your appointment time to register for the treatment.

ABOUT THE EXAM
Your physician has ordered an exam called a MRI of the prostate. The purpose of this exam is to view the prostate, including the area around it. If your physician is not a University of Chicago physician, he/she needs to fill out the two page Prostate MRI Requisition included in this packet and fax it to us at 773-834-3527.

PREPARATION FOR THE EXAM
DO NOT eat solid foods 4 hours before your arrival time.

HOW IS THE EXAM PERFORMED?
When you arrive in the MRI department, a technologist will confirm your identity and ask you questions about your medical history and ask you to fill out the MRI Safety Screening Form that is included in this packet. The technologist will ask you to change into a gown and ask you to remove all jewelry and metals, including removable dentures, and piercings. You will be provided a locker to secure your belongings. The technologist will start an intravenous line (IV) in your hand or arm and will offer the use of a restroom to empty your bladder.

To image the prostate, you will be asked to lie down on the MRI table and a special device called a coil will be inserted into the rectum directly under the prostate. You will feel mild discomfort (pressure) during the insertion, but should be comfortable during the exam. A balloon tip on the coil will be inflated to hold the coil in place.

You will be given ear plugs to help reduce the noise the MRI machine makes, a call button to communicate with the MRI technologist and positioned in the MRI machine to start the exam. The MRI technologist will be in constant contact with you during the exam. A series of images will be taken of the prostate and surrounding area. During the exam, the MRI machine is very loud. Contrast, which is a special MRI dye, will be given through the IV near the end of the exam. The exam takes about 45 minutes to an hour. After all of the images are acquired, the coil and IV will be removed. You will be helped up and shown to the restroom or to your dressing room to change back into your clothing.
AFTER THE EXAM
You may resume your normal activities and diet after the test. A radiologist will interpret the exam and the results will be sent to the ordering physician. The ordering physician will share the results with you at your follow-up appointment or notify you by phone. If you have any questions about the exam or cannot keep the appointment, please call the MRI scheduling staff at 773-795-9723.

YOUR BILL
You will receive two bills. One is from the hospital and the other is from the radiologist. Contrast is given depending on the patient's weight. Therefore, the charge varies from patient to patient. If you have any questions about your bill, please contact our billing department at 773-702-2027.
Patient Name __________________________ Date of Birth __________________________
Patient Info: Age ______ Height ______ Weight (kg) ______ Patient Contact Number ______

ATTENDING PHYSICIAN ORDERING EXAM __________________________ Phone/Pager __________________________
Form Filled Out By __________________________ Office Fax Number __________________________
MD/DO/NP/PA Phone/Pager __________________________ Date ______ Time ______

MD/DO/PA/NP Signature __________________________

Exam/Procedure Requested

☐ MRI Pelvis With and Without Contrast (CPT: 72197)
☐ MRI Guided Prostate Biopsy (CPT: 55700, 77021) Prior Prostate MRI Imaging is required for scheduling.
History/Indication __________________________

ICD 9/10 Code(s) (Please List) __________________________

Prostate Specific History

3 Serum PSA Levels: Value ______ Date _______, Value ______ Date _______, Value ______ Date ______

Previous History of Prostate Treatment (hormone, Finasteride, radiation, surgery) and dates:

__________________________________________

__________________________________________

Previous Prostate Biopsy Results with Gleason Score __________________________

☐ Please check if you are interested in learning information about an MR Guided Focal Therapy Clinical Trial.

Additional Scheduling Instructions

• Patients should wait 6 weeks after Prostate Biopsy to perform MRI exam.
• Patients should refrain from sexual activity 48 hours prior to the MRI exam.
• For MR-guided Prostate biopsies, we need to prescribe prophylactic antibiotics (starting on the night before the biopsy and continuing on the day of biopsy).
• If the patient requires sedation for the MRI, oral sedation and instructions must be prescribed by the ordering physician and self-administered prior to the exam by the patient. The patient must have a ride home after the procedure if they are taking an oral sedative.

Please complete the required IV Contrast and MRI Safety Screening on Page 2.
PROSTATE MRI REQUISITION

MRI SAFETY SCREENING – Indicate if patient has or had:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac pacemaker, ICD, or pacing wires?</td>
<td></td>
<td></td>
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<tr>
<td>Swan-Ganz Line?</td>
<td></td>
<td></td>
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<tr>
<td>Aneurysm clips?</td>
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<tr>
<td>Artificial joint, metal plate, pin, or rod in or on a bone?</td>
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<tr>
<td>Artificial heart valve?</td>
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<tr>
<td>Metal fragments in the eyes?</td>
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<tr>
<td>Eye surgery?</td>
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<tr>
<td>Tattoo on any part of the body?</td>
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<tr>
<td>Ear surgery or implants?</td>
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<tr>
<td>Body piercing jewelry?</td>
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<tr>
<td>Vascular surgery in the brain and/or arteries?</td>
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<tr>
<td>Bullet or shrapnel, other metal fragments in the body?</td>
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<tr>
<td>Shunt?</td>
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<tr>
<td>Permanent eyeliner?</td>
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<td></td>
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<tr>
<td>Device for pain control (Tens Unit), nerve stimulator?</td>
<td></td>
<td></td>
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<tr>
<td>Greenfield Filter or IVC Filter</td>
<td></td>
<td></td>
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<tr>
<td>Is the patient claustrophobic?</td>
<td></td>
<td></td>
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<tr>
<td>Is the patient unable to lie flat for up to one hour?</td>
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</tr>
</tbody>
</table>

Contrast Safety Screening

1. If any of the conditions listed below apply to the patient, renal function tests (Creatinine) must be available within 30 days of the patient's appointment.
2. Labs must be ordered by the referring physician.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 60 and over</td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of kidney disease or renal failure</td>
<td></td>
<td></td>
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<tr>
<td>On hemodialysis or peritoneal dialysis</td>
<td></td>
<td></td>
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<tr>
<td>History of nephrogenic systemic fibrosis</td>
<td></td>
<td></td>
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<tr>
<td>Diabetic</td>
<td></td>
<td></td>
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<tr>
<td>Hypertension regarding medical therapy</td>
<td></td>
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<tr>
<td>Received an organ transplant or is being considered for a transplant</td>
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<td></td>
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</tbody>
</table>

Most Recent Lab Values

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creatinine</td>
<td></td>
</tr>
<tr>
<td>BUN</td>
<td></td>
</tr>
<tr>
<td>GFR (if available)</td>
<td></td>
</tr>
</tbody>
</table>

Requesting Signature

Requesting Clinician Signature ___________________________ Pager ___________________________

Date _______________ Time _______________
Department of Radiology
Patient MR Safety Screening Form

Patient Name __________________________ Date of Birth _____ / _____ / __________ MRN: ________________
Height ___________ Weight ___________ Allergies: __________________________________________

Do you (the patient) have any of the following items in or on your body?

☐ Yes ☐ No Aneurysm clip or coil
☐ Yes ☐ No Cardiac Pacemaker, pacer wires, or implanted cardioverter defibrillator (ICD)
☐ Yes ☐ No Neurostimulators (brain, spine, bone, etc.)
☐ Yes ☐ No Internal electrodes or wires
☐ Yes ☐ No Eye or ear implant, springs or wires (e.g cochlear implant)
☐ Yes ☐ No Tissue expanders (e.g. breast)
☐ Yes ☐ No Metallic stent, filter, coil or heart valve  Please specify type and location: ________________________
☐ Yes ☐ No Magnetically activated implant or programmable device (e.g. VP shunt)
☐ Yes ☐ No Shunt (spinal, brain or intraventricular)
☐ Yes ☐ No Insulin or other infusion pump  If Yes, please indicate if internal or external _______________________
☐ Yes ☐ No Joint replacement or any type of prosthesis (eye, hip, knee, etc.)
☐ Yes ☐ No Bone or joint pin, screw, nail, wire, plate, etc.
☐ Yes ☐ No Hearing aid
☐ Yes ☐ No Swan Ganz Catheter
☐ Yes ☐ No Surgical staples, clips, or metallic sutures
☐ Yes ☐ No Dental or partial dental plates
☐ Yes ☐ No Medication patch (Nicotine, Fentanyl, Nitroglycerine)
☐ Yes ☐ No Penile implant or pump
☐ Yes ☐ No Body piercing or tattoos
☐ Yes ☐ No Any metallic fragment or foreign body
☐ Yes ☐ No Have you had an injury to the eye involving a metallic object or fragment?
☐ Yes ☐ No Have you ever been injured by a metallic object (bullet, shrapnel, etc.)?
☐ Yes ☐ No Do you have any breathing problems or claustrophobia?

For Female Patients (Ages 9-55):

☐ Yes ☐ No Are you pregnant or suspect that you might be?
☐ Yes ☐ No Are you breast-feeding?
☐ Yes ☐ No Do you have an IUD?

Please complete the following if your exam is ordered with MRI Contrast:

☐ Yes ☐ No Do you have any allergies to contrast dye?
☐ Yes ☐ No Do you have a condition called Nephrogenic Systemic Fibrosis?
☐ Yes ☐ No Do you have any history of kidney disease or renal failure?
☐ Yes ☐ No Are you currently on dialysis?
☐ Yes ☐ No Are you diabetic?
☐ Yes ☐ No Do you have hypertension (high blood pressure) treated by medication?
☐ Yes ☐ No Have you received an organ transplant or are you being considered for a transplant?

Comments: ____________________________________________

I attest the above information is correct to the best of my knowledge. I read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MRI procedure I am about to undergo.

Patient or Legal Guardian Name (Print) __________________________ Patient or Legal Guardian Name (Sign) __________ Date/Time __________

Reviewed By Name (Print) __________________________ Reviewed By Name (Sign) __________ Date/Time __________
Driving Directions

From the NORTH:
Kennedy Expressway (I-90) and Edens Expressway (I-94) to Dan Ryan Expressway (I-90/94)
1. Take the Kennedy Expressway (I-90) east/ Edens Expressway (I-94) east, southbound to the Dan Ryan Expressway (I-90/94) east.
2. Stay in the local lanes.
3. Exit at 55th Street, also called Garfield Boulevard (exit 57B).
4. Turn left (east) on Garfield Boulevard and continue on Morgan Boulevard through Washington Park, following signs directing you to campus.
5. Continue with directions below specific to your destination.

Lake Shore Drive (US-41)
1. Travel south on Lake Shore Drive to 57th Street.
2. Exit (right) at 57th Street, just before the Museum of Science and Industry.
3. Proceed on 57th south, around the museum, following the blue hospital signs.
4. Turn right on Midway Plaisance and continue west to Cottage Grove Avenue.
5. Turn right on Cottage Grove Avenue.
6. Continue with directions below specific to your destination.

From the SOUTH:
Bishop Ford Expressway (I-57) to Dan Ryan Expressway (I-90/94)
1. Take the Bishop Ford Expressway (I-57) northbound to the Dan Ryan Expressway (I-90/94) west.
2. Stay in the local lanes.
3. Exit at 55th Street, also called Garfield Boulevard (exit 57).
4. Turn right (east) on Garfield Boulevard and continue on Morgan Boulevard through Washington Park, following signs directing you to campus.
5. Continue with directions specific to your destination.

Chicago Skyway (I-90)
1. From the Skyway, exit at Stony Island Avenue.
2. Follow Stony Island Avenue north just past 71st Street, staying to your left to continue on to Stony Island Avenue.
3. Just after 60th Street, turn left (west) onto Midway Plaisance and continue to Cottage Grove Avenue.
4. Turn right on Cottage Grove Avenue.
5. Continue with directions below specific to your destination
6. Lake Shore Drive (US-41)
7. Take Lake Shore Drive north to 57th Street.
8. Exit left (west) at 57th Street and head south, around the Museum of Science and Industry, following the blue hospital signs.
9. Turn right on Midway Plaisance and continue west to Cottage Grove Avenue.
10. Turn right on Cottage Grove.
11. Continue with directions below specific to your destination.

From the WEST:
Eisenhower Expressway (I-290) to Dan Ryan Expressway (I-90/94)
1. Take the Eisenhower Expressway (I-290) east to the Dan Ryan Expressway (I-90/94) east.
2. Continue southbound on the Dan Ryan, staying in local lanes.
3. Exit at 55th Street, also called Garfield Boulevard (exit 57B).
4. Turn left (east) on Garfield Boulevard and continue on Morgan Boulevard through Washington Park, following the signs directing you to campus.

5. Continue with directions below specific to your location. Stevenson Expressway (I-55) to Dan Ryan Expressway (I-90/94)


7. Continue southbound on the Dan Ryan, staying in local lanes.

8. Exit at 55th Street, also called Garfield Boulevard (exit 57B).

9. Turn left (east) on Garfield Boulevard and continue on Morgan Boulevard through Washington Park, following the signs directing you to campus.

10. Continue with directions below specific to your location.

**Parking**

We encourage patients and visitors to use our Valet Parking service. It’s convenient and usually less expensive than self-parking. Valet Parking is offered directly in front of all of our Patient Care Facilities: Bernard A. Mitchell Adult Hospital, Duchossois Center for Advanced Medicine, Comer Children’s Hospital and the Center for Care and Discovery.

To ensure traffic moves smoothly, please do not enter campus at 58th Street and Cottage Grove Avenue. Please only use 58th Street for exiting the medical campus.

For parking-related questions, contact the Parking Office at (773) 702-4381, Monday through Friday, 7:30 a.m. to 4:30 p.m. Valet parking hours are Monday through Friday, 5 a.m. to 9 p.m.