

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date ____/____/____

Patient Number _____

Name _____

Last Name

First Name

Middle Initial

Date of Birth ____/____/____ Age ____ Weight ____
Month Day Year

Briefly explain the reason you are having an MRI today: _____

- | | | |
|--|-----|----|
| 1. Have you had prior surgery on the body part being examined today? | Yes | No |
| 2. Have you had a prior diagnostic exam (MRI, CT, Ultrasound, X-ray, etc.) on the body part being examined today?
If yes, please describe the type and date of the exam _____ | Yes | No |
| 3. Did you bring films from a prior exam with you today? | Yes | No |
| 4. Have you experienced any problem related to a previous MRI exam or MR Procedure? If Yes, please describe _____ | Yes | No |
| 5. Have you had an injury to the eye involving a metal object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)?
If Yes, please describe _____ | Yes | No |
| 6. Have you ever been injured by a metal object or foreign body (e.g. BB, bullet, shrapnel, etc.)? If Yes, please describe _____ | Yes | No |
| 7. Are you currently taking or have you recently taken any medication or drug? If yes, please list _____
_____ | Yes | No |
| 8. Are you allergic to any medication?
If yes, please list _____ | Yes | No |
| 9. Do you have a history or asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye use for an MRI, CT, or X-Ray Exam? | Yes | No |
| 10. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease or seizures?
If yes, please describe _____ | Yes | No |

This group of questions is for female patients only:

- | | | |
|---|-----|----|
| 11. Are you pregnant or experiencing a late menstrual period? | Yes | No |
| 12. Are you currently breastfeeding? | Yes | No |

TECH NOTES:

Please Fill Out the Back Side of This Form



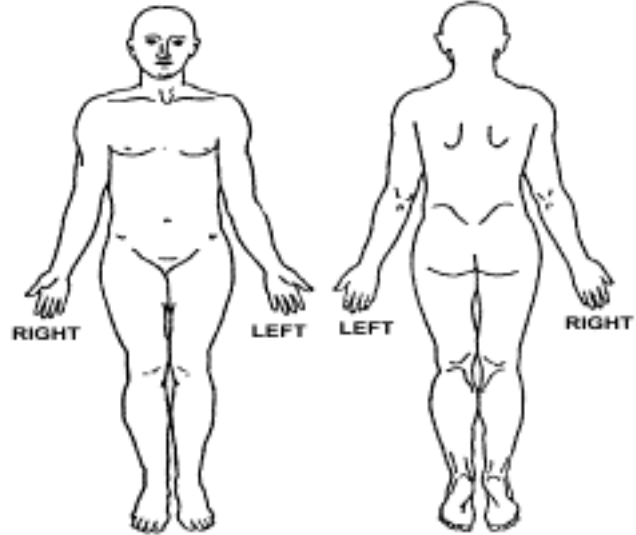


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. **The MR system magnet is ALWAYS on.**

Please indicate if you have any of the following:

- Yes No Aneurysm clip(s)
- Yes No Cardiac pacemaker
- Yes No Implanted cardioverter defibrillator (ICD)
- 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 Tattoo or permanent makeup
- Yes No Body piercing jewelry
- Yes No Hearing aid
(Remove before entering MR system room)
- Yes No Other implant _____
- Yes No Breathing problem or motion disorder
- Yes No Claustrophobia

Please mark on the figure(s) below 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 all 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, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

I attest that 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 MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date ____/____/____
Signature

Form Completed By: Patient Relative Nurse _____
Print name Relationship to patient

Form Information Reviewed By: _____
Print name Signature

MRI Technologist Nurse Radiologist Other _____