MAGNETIC RESONANCE (MRI) PROCEDURE SCREENING FORM FOR PATIENTS

Date:_____ Patient Number: _____

Name:_____ Age:_____ Height: _____ Weight:_____

Date of Birth: _____ Male ( ) Female ( ) Body Part to be Examined:

Reason for MRI and/or Symptoms:_____

Referring Physician:_____

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1. Have you had prior surgery or an operation (e.g. arthroscopy, endoscopy, etc.) of any kind? ( ) No ( ) Yes

If yes, please indicate the date and type of surgery:

Type of Surgery:_____ Date:_____

Type of Surgery:_____ Date:_____

2. Have you had a prior diagnostic imaging study examination (MRI, CT, Ultrasound, X-ray, etc.)? ( ) No ( ) Yes

If Yes, please list:	Body Part	Date	Facility
MRI:	_____	_____	_____
CT/CAT Scan	_____	_____	_____
X-Ray:	_____	_____	_____
Ultrasound:	_____	_____	_____
Nuclear Medicine:	_____	_____	_____
Other:	_____	_____	_____

3. History of cancer? ( ) No ( ) Yes

If yes, what type, when:_____

4. Have you experienced any problem related to a previous MRI examination or MR procedure? ( ) No ( ) Yes

If yes, please describe:_____

5. Have you had an injury to the eye involving a metallic object or fragment (e.g. metallic slivers, shavings, foreign body, etc.)? ( ) No ( ) Yes

If yes, please describe:_____

6. Have you ever been injured by a metallic object or foreign body (e.g. BB, bullet, shrapnel, etc.)? ( ) No ( ) Yes

If yes, please describe:_____

7. Are you currently taking or have you recently taken any medication or drug? ( ) No ( ) Yes

If yes, please list:_____

8. Are you allergic to any medication? ( ) No ( ) Yes

If yes, please list:_____

9. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT or X-ray examination? ( ) No ( ) Yes

10. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes or seizures? ( ) No ( ) Yes

If yes, please describe:_____

For female patients:

10. Date of last menstrual period:_____ Post menopausal? ( ) No ( ) Yes

11. Are you pregnant or experiencing a late menstrual period? ( ) No ( ) Yes

12. Are you taking oral contraceptives or receiving hormonal treatment? ( ) No ( ) Yes

13. Are you taking any type of fertility medication or having fertility treatments? ( ) No ( ) Yes

If yes, please describe:_____

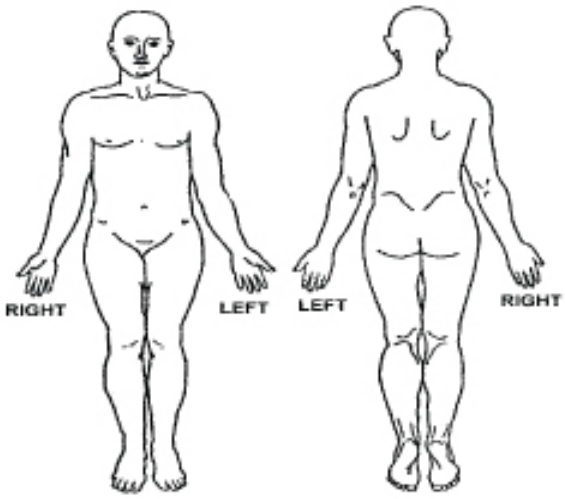
14. Are you currently breastfeeding? ( ) No ( ) Yes

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, artifical limb)
( ) Yes ( ) No Heart valve prosthesis
( ) Yes ( ) No Eyelid spring or wire/implant/**METAL IN EYE**
( ) 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 (prostate, breast, etc.)
( ) 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/Braces
( ) Yes ( ) No Tattoo or permanent makeup
( ) Yes ( ) No Body piercing jewelry/earrings/hair pins
( ) Yes ( ) No Hearing aid ***(remove before entering MR scan room)***
( ) Yes ( ) No Other implant:
( ) Yes ( ) No Breathing problem or motion disorder
( ) Yes ( ) No Claustrophobia
( ) Yes ( ) No Shrapnel/bullets
( ) Yes ( ) No Transdermal patches

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, bepper, 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 conern 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:_____

Form Completed By: ( ) Patient ( ) Relative ( ) Nurse_____
Print Name Relationship to Patient

Form Information Reviewed By: _____
Print Name Signature

( ) MRI Technologist ( ) Nurse ( ) Radiologist ( ) Other: _____