

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

PLEASE USE BLACK OR BLUE INK

Date _____ Time _____ (scheduled) Study Number(s) _____

Name _____ Age _____ Height _____ Weight _____
Last name First name Middle Initial

Date of Birth _____ Male Female
month day year

Body Part to be examined _____ Referring Physician _____

Tech Notes: _____

_____ Contrast _____

Have you ever had any surgery or procedure on the part of the body we're scanning today? No Yes

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

Have you ever had any other surgery or procedure that left any implanted metallic or electronic devices? No Yes

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

Have you ever had an MRI before? If yes, body part? _____ No Yes

If yes, location and date? (month/year) _____

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

If yes, please describe: _____

Have you had any other diagnostic imaging studies on the part of the body we're scanning today? No Yes

X-ray When _____ Where _____

CAT Scan (CT) When _____ Where _____

Bone Scan When _____ Where _____

Have you had an injury to the eye involving metallic objects/fragments (metallic slivers, shavings, etc.)? No Yes

If yes, please describe: _____

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

If yes, please describe: _____

Are you currently taking or have you recently taken any medication or drug? No Yes

If yes, please list: _____

Are you allergic to any medication? No Yes

If yes, please list: _____

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

Do you have any renal (kidney) disease, reduced renal function or renal failure? No Yes

Do you have any known personal history of Cancer? No Yes

If yes, please list: _____

Have you ever undergone chemo- or radiation therapy? No Yes

If yes, when & what body part (radiation): _____

Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease or seizures? No Yes

If yes, please describe: _____

Are you currently a smoker or have you smoked regularly in the past? No Yes

If yes, how many packs per day _____ and for how long _____

For female patients:

Date of last menstrual period: ____/____/____ Postmenopausal? No Yes

Are you pregnant or experiencing a late menstrual period? No Yes

Are you currently breastfeeding? No Yes

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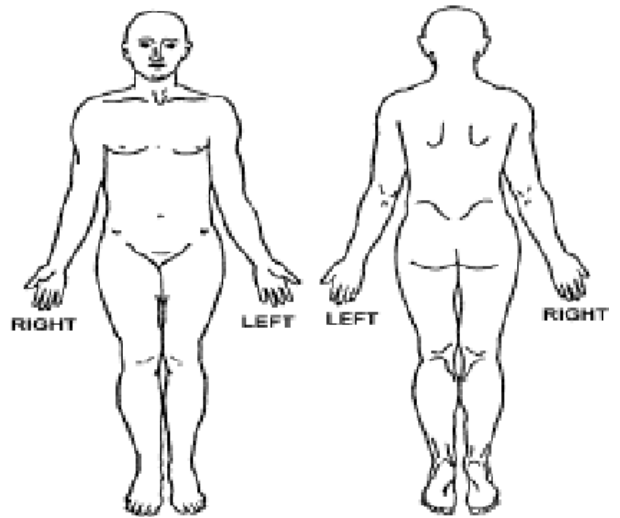


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object.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

- Aneurysm clip(s) No Yes
- Cardiac pacemaker No Yes
- Implanted cardioverter defibrillator (ICD) No Yes
- Any other electronic implant or device No Yes
- Magnetically-activated implant or device No Yes
- Neurostimulation system No Yes
- Spinal cord stimulator No Yes
- Internal electrodes or wires No Yes
- Bone growth/bone fusion stimulator No Yes
- Cochlear, otologic, or other ear implant No Yes
- Insulin or other infusion pump No Yes
- Implanted drug infusion device No Yes
- Any type of prosthesis (eye, penile, etc.) No Yes
- Heart valve prosthesis No Yes
- Eyelid spring or wire No Yes
- Artificial or prosthetic limb No Yes
- Metallic stent, filter, or coil No Yes
- Shunt (spinal or intraventricular) No Yes
- Vascular access port and/or catheter No Yes
- Radiation seeds or implants No Yes
- Swan-Ganz or thermodilution catheter No Yes
- Medication patch (Nicotine, Nitroglycerine) No Yes
- Any metallic fragment or foreign body No Yes
- Wire mesh implant No Yes
- Tissue expander (e.g., breast) No Yes
- Surgical staples, clips, or metallic sutures No Yes
- Where: _____
- Joint replacement (hip, knee, etc.) No Yes
- Bone/joint pin, screw, nail, wire, plate, etc. No Yes
- IUD, diaphragm, or pessary No Yes
- Dentures or partial plates No Yes
- Tattoo or permanent makeup No Yes
- Body piercing jewelry No Yes
- Hearing aid (*Remove before entering MRI room*) No Yes
- Other implant _____ No Yes
- Breathing problem or motion disorder No Yes
- Claustrophobia No Yes

Please mark on the figure(s) below the location of any area of pain related to the exam you are having today



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 will be required to wear earplugs or other hearing protection during the MR procedure to prevent possible problems or hazards related to acoustic noise.

NOTE: Notify MR staff immediately if "YES" to any of the above.

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 MRI Tech Assistant Radiologist Other _____