

MRI SCREENING FORM: PATIENT

Date ____ / ____ / ____

Patient Identification No. _____

Name _____
Last Name, First Name, Middle Initial

Date of Birth ____ / ____ / ____

Male Female

Height ____ ft. Weight ____ lbs.

Referring Physician _____

Telephone No. (____) ____ - _____

Body part to be examined by MRI? _____

Why are you having an MRI examination (medical problem or symptoms)? _____

Briefly describe your symptoms: _____

List your current medications: None _____

List your allergies including allergies to drugs: None _____

List your prior diagnostic imaging exams (MRI, CT, PET, Ultrasound, X-ray, etc.): None Facility

	Body part	Date	
MRI	_____	____ / ____ / ____	_____
CT/CAT Scan	_____	____ / ____ / ____	_____
X-Ray	_____	____ / ____ / ____	_____
Ultrasound	_____	____ / ____ / ____	_____
Nuclear Medicine	_____	____ / ____ / ____	_____

Have you had a prior surgery, operation, (e.g., endoscopy, colonoscopy, etc.) or medical procedure? No Yes

If yes, list the approximate date and type: _____

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

If yes, please describe: _____

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

If yes, please describe: _____

Have you ever been injured by a metallic object or foreign body, including being injured in the eye(s) or face (e.g., slivers, BB, bullet, shrapnel, etc.)? No Yes

If yes, please describe: _____

Do you have a breathing problem or movement disorder? No Yes

If yes, please describe: _____

For female patients:

Date of last menstrual period: ____ / ____ / ____

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

Are you taking oral contraceptives or receiving hormonal treatment? Type: _____ No Yes

Are you currently breastfeeding? No Yes

Are you post-menopausal? No Yes

IMPORTANT WARNING: Certain metallic medical implants or metallic foreign bodies may be harmful to you and/or may interfere with the MRI examination. Do not enter the MR system room if you have any question or concern regarding a metallic implant or metallic foreign body. Consult the MRI Technologist before entering the MR system room.

HEARING PROTECTION: Because some patients find the noise levels associated with the MRI exam unacceptable, and the noise levels may affect your hearing, you will be provided with hearing protection such as foam earplugs or other hearing protection prior to your MRI exam.

IMPORTANT INSTRUCTIONS: Before entering the MRI system room, you must remove all metallic objects including external hearing aids, dentures, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, credit cards, bank cards, magnetic strip cards, clothing with metal fasteners, & clothing with metallic threads. The MRI technologists will provide you with an MR Safe gown or scrubs.

Do you have anything in or on your body that you were not born with (for example, an aneurysm or brain clip, cardiac pacemaker, neurostimulation system, electronic implant, or a metallic foreign body such as a sliver or shrapnel)?
 No Yes (See section below and provide details)

If you answered No, sign this section of the form to confirm that you understand the question and that you have no metallic implant or metallic foreign body that may cause you harm during the MRI examination.

Acknowledgement: By signing below, I confirm that I read and understand the question indicated above.

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

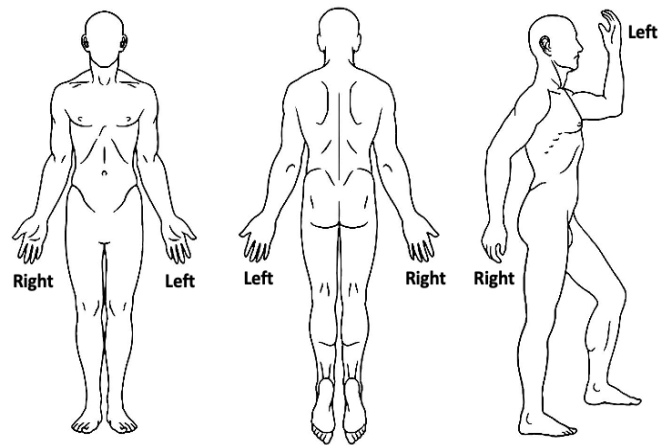
MRI Technologist Nurse Radiologist Other _____

NOTE: If you answered No to the question in the above section, you do not need to complete the next section.

ATTENTION: The following items may be harmful to you and/or interfere with the MRI examination. To ensure your safety and to avoid issues, you must indicate if you have any item listed below (check the box). If you have questions, please ask the MRI Technologist.

- Electronically- or magnetically activated implant
Type: _____ Unknown
- Cardiac (heart) pacemaker
Type: _____ Unknown
- Implantable cardioverter defibrillator (ICD)
Type: _____ Unknown
- Neurostimulation system used for spinal cord stimulation, deep brain stimulation, bone fusion stimulation, vagus nerve stimulation, or other stimulation system.
Type: _____ Unknown
- Implant or prosthesis held in place by a magnet
Type: _____ Unknown
- Other implant or device
Type: _____ Unknown
- Unknown implant, device, or other item
Body part: _____
- Implanted drug infusion pump
- Implanted or external insulin pump
- Cochlear implant or other internal hearing implant
- External hearing aid
- Internal electrodes, leads, or wires
- Aneurysm (brain) clip
- External fixation system
- Artificial or prosthetic limb or similar appliance
- Any shunt (e.g., CSF, intraventricular, etc.)
- Any ingested "pill camera" or other ingested device
- Orthopedic implant (i.e., spinal, total hip, total knee, or other joint implant) Type: _____ Unknown
- Medication patch Type: _____ Unknown
- Surgical staple(s), clip(s), or metallic suture(s)
- Endoscopy or colonoscopy in the last 90 days

Mark on the figure(s) below the location of any implant or metal inside of or on your body.



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.

Signature of Person Completing Form: _____

Date ____ / ____ / ____

Form Completed By: _____

Print Name

Relationship to Patient

Form Information Reviewed By: _____

Print Name

Signature

- MRI Technologist
- Nurse
- Radiologist
- Other _____