

Magnetic Resonance (MR) Procedure Screening Form for Patients

Staff Notes: _____

Signature: _____ Date/Time: _____

Reason for MRI and / or Symptoms: _____

1. Prior surgeries or operations (e.g., arthroscopy, endoscopy, etc) of any kind? No Yes
 If yes, please indicate the date and type of surgery:
 Date: _____ Surgery Type: _____
 Date: _____ Surgery Type: _____

2. Prior diagnostic imaging study or 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. Have you experienced any problems related to a previous MRI examination or MR procedure? No Yes
 If yes, please describe: _____

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, etc.)? No Yes
 If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? No Yes
 If yes, please describe: _____

6. 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 If yes, explain: _____

7. Please check if you have the following: Anemia Blood Disorder Renal (Kidney) Disease Seizures
 Please describe: _____

For female patients only:

8. Date of last menstrual period: _____ Post menopausal? No Yes

9. Pregnant or experiencing a late period? No Yes

10. Taking oral contraceptives or receiving hormonal treatment? No Yes

11. Taking any type of fertility medication or having fertility treatments? No Yes
 If yes, please describe: _____

12. Currently breastfeeding? No Yes

Form Information Reviewed By: _____ Date/Time: _____

SEE NEXT PAGE



PATIENT LABEL MUST
BE PLACED WITHIN
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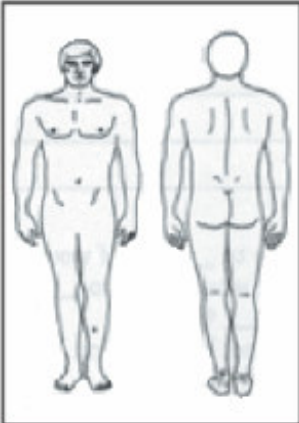


WARNING: Certain implants, devices, or objects may be hazardous to you and / or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device or object.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

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

Please mark on the figures 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 clippers, tools, clothing with metal fasteners, and clothing with metal threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern **BEFORE** entering 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.

Information Reviewed By: _____ Date/Time: _____
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Please list current medications / drugs: none

Please list any allergies: none

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 the MR procedure that I am about to undergo.

Signature of person completing form: _____ Date: _____

Form completed by: Patient Relative Nurse If not patient, relationship to patient: _____

Form Information Reviewed By: _____ Date/Time: _____

MRI Technologist Nurse Radiologist Other _____



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