

Magnetic Resonance Imaging Screening Form

Reading Radiologist: _____ Nucleus: Yes No



WARNING: IF YOU HAVE A PACEMAKER, DEFIBRILLATOR, OR ANEURYSM CLIP, DO NOT PROCEED WITH YOUR SCAN. PLEASE NOTIFY A STAFF MEMBER IMMEDIATELY.

Patient Name (please print): _____ Date: _____
Age: _____ Date of Birth: _____ Weight: _____ Gender: Male Female:

Please review and answer the following questions:

1. Have you ever had a prior surgical procedure of any kind? Yes No
If yes, please indicate the date (approximate if unknown) and type of surgery: _____

2. Have you ever experienced any problem related to a previous MRI procedure? Yes No
If yes, please explain: _____
3. Do you have any respiratory concerns that could prevent you from having an MRI procedure? ... Yes No
If yes, please explain: _____
4. Have you ever been a welder, grinder, or sheet metal worker? Yes No
If yes, please explain: _____
5. Have you had an eye injury involving a metallic object or fragment (metallic slivers, shavings)? Yes No
If yes, please explain: _____
6. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel)? Yes No
If yes, please explain: _____
7. Have you recently had a small bowel endoscopy/colonoscopy in the past 30 days? Yes No
If yes, how recent: _____
8. 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, or seizures? Yes No
If yes, please explain: _____
9. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to contrast medium or dye used for MRI, CT, or X-ray procedures? Yes No
If yes, please explain: _____
10. Have you ever had a reaction to or have been told that you should not have contrast medium injections for imaging studies? Yes No
If yes, please explain: _____

Female Patients Only

1. Are you or could you be pregnant or experiencing a late menstrual period? Yes No
2. Do you have a diaphragm/IUD in place? Yes No
3. Are you currently breastfeeding? Yes No



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Please indicate if you currently have or ever had any of the following:

Aneurysm clip(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation seeds or implants	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swan-Ganz or thermodilution catheter	<input type="checkbox"/> Yes <input type="checkbox"/> No
Implanted cardioverter defibrillator (ICD)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Medical patch (transdermal) (e.g. nicotine, nitroglycerine)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Electronic implant or device	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any metallic fragment or foreign body	<input type="checkbox"/> Yes <input type="checkbox"/> No
Magnetically activated implant or device	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wire mesh implant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurostimulator (TENS unit)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tissue expander (e.g. breast)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Spinal cord stimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Surgical staples, clips, or metallic sutures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bone growth/bone fusion stimulator	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint replacement (hip, knee, etc.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Internal electrodes or wires	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bone/joint pin, screw, nail, wire, plate, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cochlear, otologic, or other ear implant	<input type="checkbox"/> Yes <input type="checkbox"/> No	Intrauterine device (IUD), diaphragm or pessary	<input type="checkbox"/> Yes <input type="checkbox"/> No
Insulin or other infusion pump	<input type="checkbox"/> Yes <input type="checkbox"/> No	Braces, dentures, or partial plates	<input type="checkbox"/> Yes <input type="checkbox"/> No
Any type of prosthesis (e.g., eye, penile)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tattoo or permanent makeup	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart valve prosthesis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Body piercing jewelry	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood clot filter	<input type="checkbox"/> Yes <input type="checkbox"/> No	Wig or hair implants	<input type="checkbox"/> Yes <input type="checkbox"/> No
Eyelid spring or wire	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hair accessories (e.g., hairpins)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial or prosthetic limb	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other implant	<input type="checkbox"/> Yes <input type="checkbox"/> No
Metallic stent, filter, or coil	<input type="checkbox"/> Yes <input type="checkbox"/> No	Breathing problem or motion disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Shunt (spinal or intraventricular)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Claustrophobia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Vascular access port and/or catheter (e.g., Broviac, Port-A-Cath, Hickman)	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing aid	<input type="checkbox"/> Yes <input type="checkbox"/> No



IMPORTANT INSTRUCTIONS

Please remove all metallic objects before entering the MRI scan room, including the following: jewelry (e.g., earrings, rings, body piercings), hairpins, hair clips, dentures, false teeth, partial dental plates, hearing aids, eyeglasses, watch, pager, cell phone, keys, safety pins, paperclips, money clip, any magnetic strip cards (e.g., bank, credit), coins, pens, pocketknife, nail clippers, tools, and clothing with metal fasteners or containing metal thread.

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

I have reviewed the above information and attest that the information is accurate to the best of my knowledge. I have read and understand the entire contents of this form and had the opportunity to ask questions regarding this information and the MRI procedure.

Patient Name (please print): _____

Patient Signature: _____ Date: _____

OFFICE USE ONLY

Gadolinium: _____ cc Injection time: _____ Injection site: _____ Technologist: _____

Physician Signature: _____ Date: _____ Time: _____

Technologist Notes: _____