Magnetic Resonance (MR) Procedure Screening Form for Patients

Patient Number _____

Name_____ Age_____ Weight_____
Last Name First Name Middle Initial

❑ Male ❑ Female Body Part to be Examined _____

Reason for MRI and/or Symptoms _____

How long have you had these symptoms and/or when did the injury occur? _____

1. Have you ever had any surgery on any part of your body? ❑ Yes ❑ No
   If yes, please indicate the date and type of surgery: _____
   _____
   _____

2. Have you ever had an MRI of any part of your body? ❑ Yes ❑ No
   If yes, please list: _____
   What were the results of the above tests?_____

3. Have you experienced any problem related to a previous MRI? ❑ Yes ❑ No
   If yes, please describe: _____

4. Have you had other studies related to this condition? (i.e., x-ray, CT, sono or MRI) ❑ Yes ❑ No
   If yes, when and where: _____

5. Have you had a personal history of cancer? ❑ Yes ❑ No
   If yes, please describe: _____

6. Have you had a history of metal working without wearing eye protection? ❑ Yes ❑ No

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

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

9. Are you currently taking or have you recently taken any medication or drug? ❑ Yes ❑ No
   If yes, please list:_____

10. Are you allergic to any medication? ❑ Yes ❑ No
    If yes, please list: _____

Do you have the following?

❑ Yes ❑ No Any allergies If yes, please list:_____
❑ Yes ❑ No Anemia or disease affecting your blood (Sickle Cell or Hemolytic Anemia)
❑ Yes ❑ No Renal (kidney) disease
❑ Yes ❑ No Renal (kidney) failure
❑ Yes ❑ No Renal (kidney) transplant
❑ Yes ❑ No Liver (hepatic) disease, liver transplant or pending transplant
❑ Yes ❑ No High blood pressure (hypertension)
❑ Yes ❑ No History of diabetes
❑ Yes ❑ No Are you breast feeding?

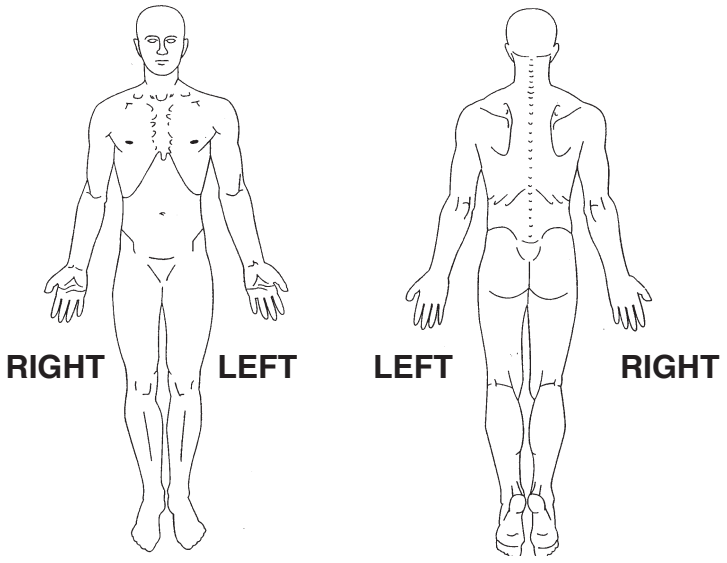
(Please complete and sign the reverse side)

The following items can interfere with the Magnetic Resonance Imaging and some may be hazardous to your safety.

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, etc.)
- ❑ Yes ❑ No Heart valve prosthesis
- ❑ Yes ❑ No Eyelid spring or wire
- ❑ 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
- ❑ 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
- ❑ Yes ❑ No Tattoo or permanent makeup
- ❑ Yes ❑ No Body piercing jewelry
- ❑ Yes ❑ No Hearing aid
  (*Remove before entering MR system room*)
- ❑ Yes ❑ No Other implant
- ❑ Yes ❑ No Breathing problem or motion disorder
- ❑ Yes ❑ No Claustrophobia
- ❑ Yes ❑ No Are you wearing any clothing, including underwear that may contain metallic fibers or is designed with special anti-odor or anti-bacterial properties?

Please mark on the figure(s) below the location of any symptoms.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove <u>all</u> loose objects including hearing aids, dentures, partial plates, eyeglasses, hair pins, jewelry, body piercing jewelry, wallets, clothing with metal fasteners and 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 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 information provided on both sides of this form 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

_____ _____

Print name Relationship to patient

Form Information Reviewed By: _____

Initials