

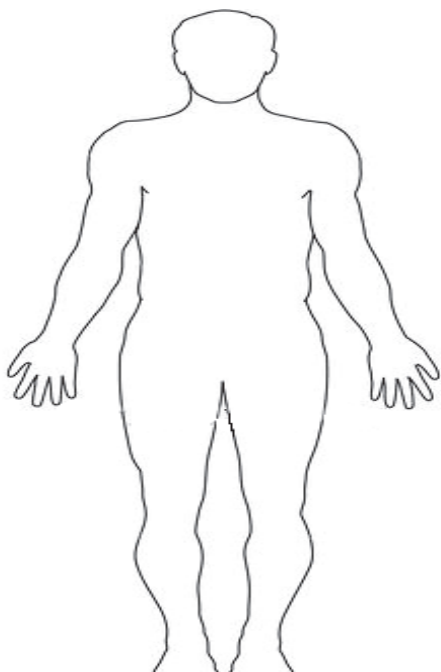
## MRI PATIENT SCREENING FORM

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

Ordering Physician: \_\_\_\_\_ Procedure: \_\_\_\_\_

Please indicate if you have any of the following:

YES	NO		
		Cardiac pacemaker – if Yes, <b>DO NOT PROCEED</b> with exam	Please mark on the figure below the location of any implant or metal, inside or on your body.
		Aneurysm clip(s)	
		Claustrophobia	 <p style="text-align: center;">R <span style="margin-left: 200px;">L</span></p>
		Implanted cardiac defibrillator (ICD)	
		Neurostimulator	
		Any Biostimulator: Type _____	
		Electronic, mechanical or magnetic implant device	
		Internal electrodes or wires(e.g. pacing)	
		Bone growth/bone fusion stimulator	
		Cochlear, otologic or other ear implants	
		Implanted drug pump(e.g. insulin, chemotherapy, pain medication)	
		Swan-Ganz or thermodilution catheter	
		Any type of prosthesis (e.g. eye, penile, etc)	
		Stent, coil, filter or shunt (spinal or intraventricular)	
		Vascular access port and/or catheter	
		Patch-type drug infusion device (e.g. pain patch, hormone replacement, nicotine, etc)	
		Artificial heart valve	
		Metallic fragment of foreign body (e.g. shrapnel, bullet, BB)	
		Magnetically-activated implant or device	
		Surgical clips, staples or metallic sutures	
		Artificial limb or joint	
		Joint replacement (hip, knee, etc.)	
		Bone/joint pins, screw, nail, wire, plate, etc	
		Tissue expander or implants (e.g. breast, hair, etc)	
		Tattoos or permanent make-up*	
		Arterial line transducer	
		<p>*A SMALL PERCENTAGE OF PATIENTS WITH TATTOOED EYELINER HAVE EXPERIENCED TRANSIENT SKIN IRRITATION IN ASSOCIATION WITH MRI. THEREFORE, YOU MUST DECIDE IF THIS SLIGHT RISK WARRANTS UNDERGOING YOUR EXAM. YOU MAY WISH TO DISCUSS THIS MATTER WITH YOUR PHYSICIAN.</p>	<p style="text-align: center;"><b>IMPORTANT INSTRUCTIONS!</b></p> <p>Before entering the MR area, you must remove <u>all</u> metallic objects including hearing aids, dentures, false teeth, partial dental plates, eyeglasses, jewelry (e.g. necklaces, pins, rings, watch), hair pins (bobby pins, barrettes, clips, etc.) pager, cell phones, credit and bank cards and all other cards with a magnetic strip, and any body piercing objects.</p> <p><b>NOTE:</b> You may be advised to wear ear plugs or to use headphones that we supply during the MR examination. Since, some patients may find the noise levels unacceptable.</p>

## MRI PATIENT SCREENING FORM

YES NO Have you ever had an MRI before? If yes, when \_\_\_\_\_

YES NO Did you have any problems? If yes, please describe \_\_\_\_\_

YES NO Are you able to lie flat or still?

YES NO Have you had a surgical operation/procedure of any kind? If yes, please list with approximate dates:  
\_\_\_\_\_

YES NO Have you ever been exposed to metal fragments (metallic slivers/shavings, foreign objects) that can be lodged in your eyes or body? If yes, please describe \_\_\_\_\_

### CONTRAST HISTORY:

YES NO Do you have any allergies (medication, food, latex)? If yes, please list \_\_\_\_\_

YES NO Have you ever received a contrast agent or x-ray dye used for MRI, CT or other x-ray study?

YES NO Have you ever had a reaction to a contrast agent used for MRI or CT? \*\* If yes, please describe \_\_\_\_\_

YES NO Do you have a history of renal disease, seizures, asthma, allergic respiratory disease or liver disease?

YES NO Do you have anemia or diseases that affect the blood? Please list: \_\_\_\_\_

YES NO Do you have diabetes? If yes, are you taking any of the following?  
 Glucophage    Glyburide    Glucovane    Other: \_\_\_\_\_

### FOR FEMALE PATIENTS ONLY

Date of last menstrual period: \_\_\_\_\_ Post-menopausal? YES NO

YES NO Are you pregnant or suspect you may be pregnant?

YES NO Are you breast-feeding?

YES NO Diaphragm, IUD, Pessary? Other types of birth control: \_\_\_\_\_

**I have informed the technologist that I am not pregnant at this time. PT. INITIALS** \_\_\_\_\_

\*\*I UNDERSTAND THAT BY CONSENTING TO THE USE OF GADOLINIUM, I MAY BE RECEIVING IT FOR USES OTHER THAN ITS FDA APPROVED INDICATIONS. I HAVE HAD THE RISKS AND POTENTIAL BENEFITS EXPLAINED TO ME. I HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS AND HAD ALL MY QUESTIONS ANSWERED TO MY SATISFACTION. I CONSENT TO THE PERFORMANCE OF AN MRI AND IF APPLICABLE, CONSENT TO THE ADMINISTRATION OF GADOLINIUM DURING THIS EXAM.

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

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**MD/RN/RT Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print MD/RN/RT Name:** \_\_\_\_\_