Magnetic Resonance (MR) Procedure Screening Form For Patients

Date _____/_____/_____

Name ____________________________________________________________ Age ________ Weight __________

Last name                                  First name                                   Middle Initial

Date of Birth _____/_____/_____         Male □  Female □  Body Part to be Examined _______________________

Reason for MRI and/or Symptoms __________________________________________________________________

Referring Physician _______________________________________________________________________________

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind? □ No  □ Yes
   If yes, please indicate the date and type of surgery:
   Date _____/_____/_____ Type of surgery _________________________________________________________
   Date _____/_____/_____ Type of surgery _________________________________________________________

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

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

5. Are you allergic to any medication? □ No  □ Yes
   If yes, please list:_____________________________________________________________

6. Do you have a 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, please describe ________________________________________________________

7. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, or seizures?
   □ No  □ Yes       If yes, please describe: ________________________________________________________

8. **For female patients:** The FDA has not established any criteria under which a pregnant woman may be scanned.
   Therefore, it is the policy of this facility that MR imaging NOT be routinely performed on a woman known or sus-
  pected to be pregnant.
   Are you pregnant or breastfeeding? □ Yes    □ No

To be completed by Medical Staff: Creatinine_________________     Contrast___________________
Please indicate if you have any of the following:

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

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.

Please consult the MRI Technologist if you have questions or concerns before you enter the MR Suite.

I have read and understood and hereby consent to this MRI examination. I understand the use of contrast material may be recommended by my doctor for this exam.

Patient Signature____________________________________________________________Date:_______________

I have reviewed and discussed these safety items with the above signed patient or guardian and approve this patient for magnetic resonance imaging.

Technologist Signature: ________________________________ Date: ______________

PH-037-000 Rev. 5/7/18