



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

Table with 4 columns: If yes, please list; Body part; Date; Facility. Rows include MRI, CT/CAT Scan, X-Ray, Ultrasound, Nuclear Medicine, and 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 suspected to be pregnant.

Are you pregnant or breastfeeding? [] Yes [] No

To be completed by Medical Staff: Creatinine _____ Contrast _____

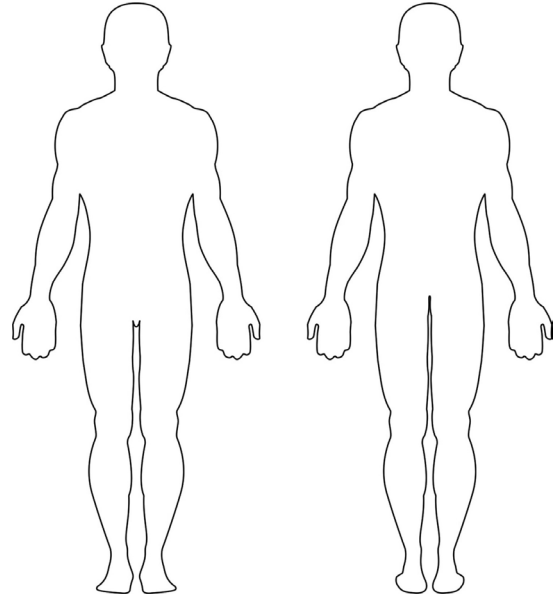


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object.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

- 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

Please mark on the figure below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR system room, you will be asked to change into a gown. Please understand that this is a safety requirement and not optional. You must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, and watch.

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: _____