

# mri screening form

Name \_\_\_\_\_ Date \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Zip code \_\_\_\_\_ Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_

Who is your ordering physician? \_\_\_\_\_

Have you ever had surgery or any similar invasive procedure on the body part on which we are doing the scan today?  No  Yes (please describe below)

Type \_\_\_\_\_ Date \_\_\_\_\_

Type \_\_\_\_\_ Date \_\_\_\_\_

Any surgery within the last 6 weeks?  No  Yes (please describe below)

Type \_\_\_\_\_ Date \_\_\_\_\_

Have you had any previous tests for the body part on which we are doing the scan today?  No  Yes (please describe below)

Type	Body Part	Date	Facility Location
MRI	_____	_____	_____
CT/CAT Scan	_____	_____	_____
X-Ray	_____	_____	_____
Ultrasound	_____	_____	_____
Nuclear Medicine	_____	_____	_____

Have you ever had a life threatening reaction to CT dye that required hospitalization?  No  Yes (please describe below)

Are you currently taking or have you recently taken any medication?  No  Yes (please describe below)

Have you ever worked with metal (grinding, fabricating, etc.) or ever had an injury to the eye involving a metallic object (e.g., metallic slivers, shavings and/or foreign bodies)?  No  Yes (please describe below)

Do you have anemia, any diseases that affects your blood or a history of renal disease or seizures?  No  Yes (please describe below)

If Female, please answer the following questions:

Date of last menstrual period \_\_\_\_\_

Are you pregnant or experiencing a late menstrual period?  No  Yes

Are you breast feeding?  No  Yes

Are you taking any type of fertility medication or having fertility treatments?  No  Yes

Are you taking oral contraceptives or receiving hormone treatments?  No  Yes

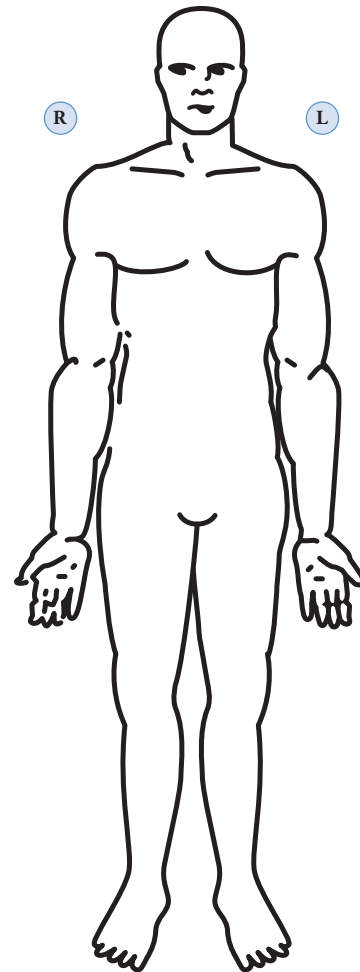
# pre-mri screening form

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination.

Please check the appropriate answer for each of the following. Do you have any of the following?

- Yes  No Cardiac pacemaker
- Yes  No Implanted cardiac defibrillator
- Yes  No Aneurysm clip(s)
- Yes  No Carotid artery vascular clamp
- Yes  No Neurostimulator
- Yes  No Insulin or infusion pump
- Yes  No Implanted drug infusion device
- Yes  No Bone growth/fusion stimulator
- Yes  No Cochlear, otologic or ear implant
- Yes  No Any type of prosthesis (eye, penile, etc.)
- Yes  No Heart Valve Prosthesis
- Yes  No Electrodes (on body, hear or brain)
- Yes  No Intravascular stents, filters or coils
- Yes  No Shunt (spinal or intraventricular)
- Yes  No Vascular access port and/or catheter
- Yes  No Swan-Ganz catheter
- Yes  No Any implant held in place by a magnet
- Yes  No Transdermal delivery system (Nitro)
- Yes  No IUD or diaphragm
- Yes  No Tattooed makeup (eyeliner, lips, etc.)
- Yes  No Body piercing(s)
- Yes  No Any metal fragments
- Yes  No Internal pacing wires
- Yes  No Aortic clip
- Yes  No Metal or wire mesh implants
- Yes  No Wire sutures or surgical staples
- Yes  No Harrington rods (spines)
- Yes  No Joint replacements \_\_\_\_\_
- Yes  No Bone/joint pin, screw, nail, wire, plate
- Yes  No Hearing aid (Remove before MRI)
- Yes  No Dentures (Remove before MRI)
- Yes  No Breathing disorder \_\_\_\_\_
- Yes  No Motion disorder
- Yes  No Claustrophobia
- Yes  No Anxiety

*On the figure to the right, please mark the location of any implant or metal inside of or attached to your body.*



*Before your MRI, please remove all metallic objects including keys, hair pins, barrettes, jewelry, watches, safety pints, paper clips, money clips, credit cards, coins, pens, belts, metal buttons, pocket knives, and clothing with metal in the material.*

Other, please explain \_\_\_\_\_

*Note: You are required to wear earplugs or earphones during the MRI Examination*

Signature of Person Completing Form \_\_\_\_\_ Date \_\_\_\_\_

Form completed:  Patient  Relative Name and relationship to patient \_\_\_\_\_  
 Physician or other Name and relationship to patient \_\_\_\_\_

*To be completed by the MRI Facility*

Medical record number \_\_\_\_\_ Completed by \_\_\_\_\_

Procedure \_\_\_\_\_ Diagnosis \_\_\_\_\_

Clinical History \_\_\_\_\_

Describe your current pain and symptoms

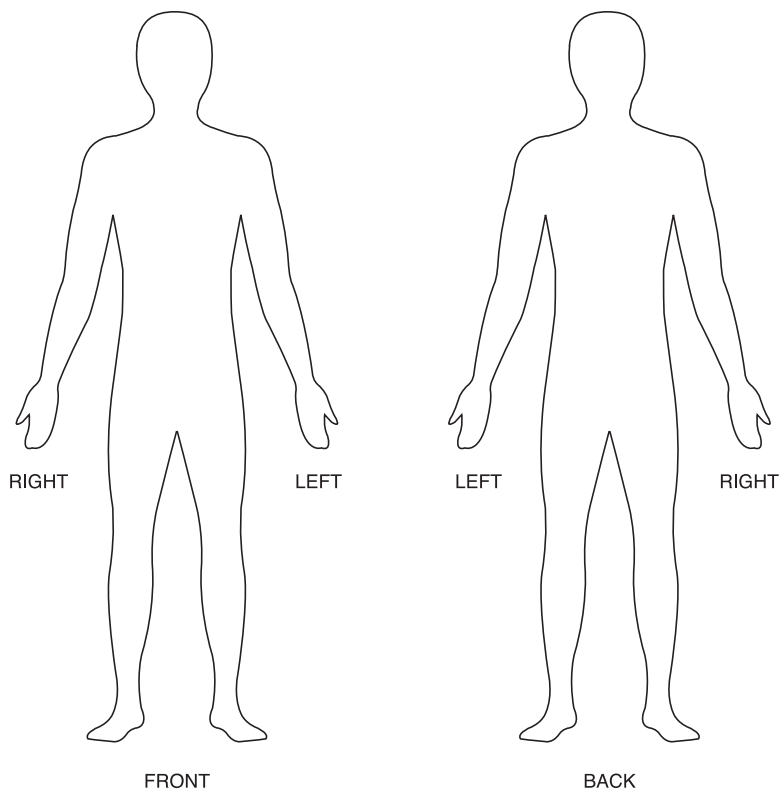
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Please indicate on the drawing where the pain is located. Be as specific as possible.



I verify that this information is correct to the best of my knowledge.

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SIGNATURE