MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FOR PATIENTS

Date: ____/____/_____ Patient Number _____

Name: _____ Age ____ Weight ____ Height: ____
Last Name First name Middle Initial

Date of Birth: ____/____/_____ ☐ Male ☐ Female Body Part to be examined _____

Address: _____ Telephone (home): ( )____-_____

City, State, Zip Code _____ Telephone (work): ( )____-_____

Reason for MRI and/or Symptoms: _____

Referring Physician: _____ Telephone: ( ) _____-_____

1. Have you had prior surgery or an operation 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, PET/CT)? ☐ No ☐ Yes

If yes, please list:	Body part	Date	Facility
MRI			
PET/CT			
Other			

3. Have you experienced any problem related to a previous MRI examination or MR procedure? ☐ No ☐ Yes
   If yes, please describe: _____
4. Have you worked with metals or 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: _____
5. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes
   If yes, please describe: _____
6. Are you currently taking or have you recently taken any medication or drug? ☐ No ☐ Yes
   If yes, please list: _____
7. Are you allergic to any medication? ☐ No ☐ Yes
   If yes, please list: _____
8. Do you have a history of asthma, emphysema, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ☐ No ☐ Yes
9. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, a history of diabetes, cancer, or seizures? ☐ No ☐ Yes
   If yes, please describe: _____
10. Have you had a procedure within the past week where you swallowed a special stomach capsule camera? ☐ No ☐ Yes
11. Have you taken an iron replacement product for iron deficiency such as Feraheme, in the last 3 months? ☐ No ☐ Yes

For female patients:

12. Date of last menstrual period: ____/____/_____ Post-menopausal? ☐ No ☐ Yes
13. Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes
14. Are you taking oral contraceptives or receiving hormonal treatment? ☐ No ☐ Yes
15. Are you taking any type of fertility medication or having fertility treatments? ☐ No ☐ Yes
    If yes, please describe: _____
16. Are you currently breastfeeding? ☐ No ☐ Yes
17. Do you have inflatable breast implants, tissue expander implants, or breast biopsy markers? ☐ No ☐ Yes

PLEASE SEE PAGE 2

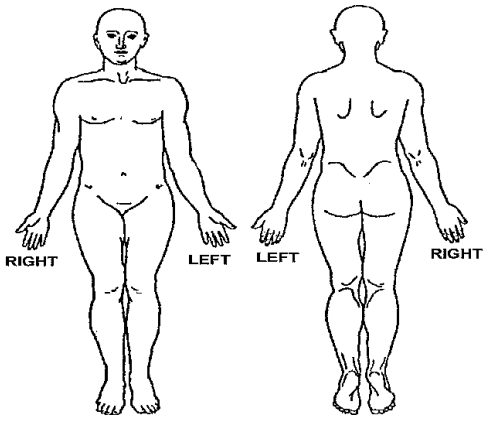
WARNING: Certain implants, devices, clothing or objects may be hazardous to you and/or may interfere with the MR procedure(i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any questions or concerns regarding an implant, device or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. The MR system magnet is ALWAYS on.

If you don't understand any of these terms (words) please ask the technologist!

Please indicate if you have any of the following:

☐ Yes ☐ No Aneurysm clip(s) or metal clips in the body or heart
☐ Yes ☐ No Cardiac (heart) pacemaker or wires
☐ Yes ☐ No Implanted cardioverter (heart) defibrillator (ICD)
☐ Yes ☐ No Electronic implant or device
☐ Yes ☐ No Magnetically-activated implant or device
☐ Yes ☐ No Neurostimulation system (TENS, Deep Brain, Bio)
☐ 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 pump, infusion pump, implanted drug infusion device
☐ Yes ☐ No Any type of prosthesis (eye, penile, etc.)
☐ Yes ☐ No Heart valve prosthesis
☐ Yes ☐ No Eye prosthesis, lens implant, cataract surgery, eyelid spring/wire
☐ Yes ☐ No Artificial or prosthetic limb
☐ Yes ☐ No Metallic stent, filter, or coil (e.g. Gianturco, Gunther IVC Filter)
☐ 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 (e.g. Nicotine, Nitroglycerine, Pain)
☐ Yes ☐ No Any metallic fragment or foreign body
☐ Yes ☐ No Any external or internal metal object
☐ 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 (s) below the location of any implant or metal inside of or on your body.



IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, guns, coins, pens, pocket knife, nail clipper, tools, weapons of all kinds, clothing with metal fasteners, & clothing with metallic threads such as Under Armour, Lululemon and Tommie Copper.

Please consult the MRI Technologist or Radiologist if you have any questions 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 the above information 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: ___/___/_____

Form Completed by: ☐ Patient ☐ Relative ☐ Nurse _____ _____
Print Name Relationship to patient

Form Information Reviewed _____ _____
Print Name Signature

☐ MRI Technologist ☐ Nurse ☐ Radiologist ☐ Other _____