



## MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Patient Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_ Wt: \_\_\_\_

1. Have you had prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) or any kind?

YES  NO

If 'yes', please indicate the date and type of surgery:

Date ____/____/____	Type of Surgery	
Date ____/____/____	Type of Surgery	
Date ____/____/____	Type of Surgery	
Date ____/____/____	Type of Surgery	
Date ____/____/____	Type of Surgery	
Date ____/____/____	Type of Surgery	
Date ____/____/____	Type of Surgery	

2. Have you had prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)?

YES  NO

If 'yes' please list:	Body Part	Date	Facility
MRI	_____	____/____/____	_____
CT/CAT SCAN	_____	____/____/____	_____

3. Have you experienced any problem related to a previous MRI examination or MR procedure?

YES  NO

If 'yes', please describe: \_\_\_\_\_

4. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)?

YES  NO

If 'yes', please describe: \_\_\_\_\_

5. Have you ever been injured by a metallic object or foreign body (e.g., BB, Bullet, Shrapnel, etc.)?

YES  NO

If 'yes', please describe: \_\_\_\_\_

6. Are you allergic to any medication?  YES  NO

If 'yes', please describe: \_\_\_\_\_

7. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for a MRI, CT or X-ray examination?  YES  NO

If 'yes', please describe: \_\_\_\_\_

8. Do you have anemia or any disease(s) that affects your blood, a history of kidney disease or seizures?

YES  NO

If 'yes', please describe: \_\_\_\_\_

**For Female Patients:**

9. Date of last menstrual period: ____/____/____	Post Menopausal?	<input type="checkbox"/> Y	<input type="checkbox"/> N
10. Are you pregnant or experiencing a late menstrual period?		<input type="checkbox"/> Y	<input type="checkbox"/> N
11. Are you currently breastfeeding?		<input type="checkbox"/> Y	<input type="checkbox"/> N

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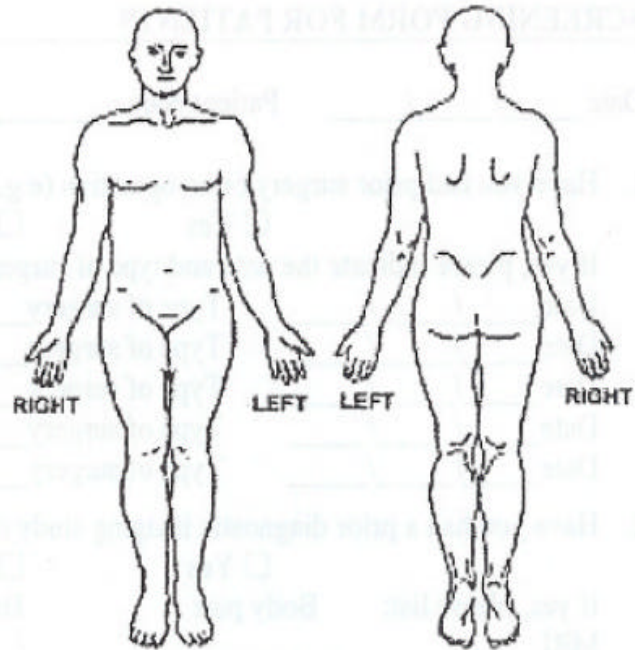


**WARNING!** Certain implants, devices, or objects may be hazardous to you and may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or the MR environment if you have any questions or concerns regarding an implant, device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

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Aneurysm Clip                                  |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Cardiac Pacemaker                              |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Implanted Cardioverter Defibrillator           |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Electronic Implant or Device                   |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Neurostimulation system                        |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Spinal Cord Stimulator                         |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Internal Electrodes or wires                   |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Bone growth/bone fusion stimulator             |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Cochlear, otologic, or other ear implant       |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Insulin or other infusion pump                 |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Implanted drug infusion device                 |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Any type of prosthesis (penile, eye, etc)      |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Heart valve prosthesis                         |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Eyelid spring or wire                          |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Artificial or prosthetic limb                  |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Metallic stent, filter or coil                 |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Shunt (spinal or intraventricular)             |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Vascular access port and/or catheter           |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Swan-Ganz or thermodilution catheter           |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Medication Patch (Nicotene, Nitroglycerin)     |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Any metallic fragment or foreign body          |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Wire mesh implant                              |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Tissue expander                                |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Surgical Staples, clips or metallic sutures    |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Joint Replacement (hip, knee, etc.)            |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Bone/joint pin , screw, nail, wire plate, etc. |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | IUD, diaphragm or pessary                      |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Dentures or partial plates                     |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Tattoo or permanent makeup                     |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Body piercing jewelry                          |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO | Hearing Aid                                    |

**Remove before entering MR system Ro**

- YES     NO    Other Implant \_\_\_\_\_



### 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 clips, credit cards, bank cards, magnetic stripe cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners (including underwire bras), clothing with metallic threads.

**Please consult your MRI Technologist or Radiologist if you have any question 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 **to prevent possible problems or hazards related to acoustic noise**

**MRI procedure**

I attest that 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: \_\_\_\_\_

Form Completed By: Patient  Relative  Nurse  \_\_\_\_\_

MRI Technologist: \_\_\_\_\_