



MAGNETIC RESONANCE PROCEDURE SCREENING FORM

DATE _____

NAME _____ AGE _____

HT _____ WT _____

DATE OF BIRTH ____/____/____ MALE FEMALE

BODY PART TO BE

EXAMINED _____

REASON FOR MRI AND/OR SYMPTOMS _____

1. Have you had prior surgery or an operation of any kind? N Y

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 exam? N Y

If yes, please list:

	BODY PART	DATE	FACILITY
MRI	_____	____/____/____	_____
CT/Cat Scan	_____	____/____/____	_____
X-Ray	_____	____/____/____	_____
Nuclear Medicine	_____	____/____/____	_____
Other	_____	____/____/____	_____

3. Have you experienced any problem related to a previous MRI exam or procedure? N Y

If yes, please describe: _____

4. Have you had any eye injury involving a metal object or fragment (e.g., metallic shavings, slivers, foreign body, etc)? N Y

If yes, please describe: _____

5. Have you ever been injured by a metallic object of foreign body (e.g., BB, bullet, shrapnel, etc.) ? N Y

If yes, please describe: _____

6. Are you currently taking any medication or drug? N Y

If yes, please list: _____

7. Are you allergic to any medication? N Y

If yes, please list: _____

8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to contrast medium or dye used for an MRI, CT or X-ray examination? N Y

9. Do you have any history of cancer? N Y

If yes, please describe: _____

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

If yes, please describe: _____

FOR FEMALE PATIENTS:

11. Date of last menstrual period: ____/____/____ Post menopausal?

12. Are you pregnant or experiencing a late menstrual period? N Y

13. Are you taking oral contraceptives or receiving hormonal treatment? N Y

14. Are you taking any type of fertility medication or having fertility treatments? N Y

If yes, please describe: _____

15. Are you currently breastfeeding? N Y

WARNING: Certain implant devices, or objects may be hazardous to you or may interfere with your M.R.I. procedure. DO NOT ENTER the MR room or MR environment if you have any questions or concerns regarding an implant device or object. Before entering the MR environment, you MUST remove ALL metallic objects including hearing aids, dentures, partial plates, keys, beepers, cell phones, eyeglasses, hair pins, barrettes, body piercings, jewelry, watches, safety pins, money clips, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knives, tools, and all clothing with metal fasteners or metallic thread. Consult the MRI technologist or Radiologist if you have any questions or concerns BEFORE entering the MR 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 seed or implants
- Yes No Swan-Ganz or thermo dilution 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 MRI ROOM)
- Yes No Claustrophobia

CONSENT FOR INTRAVENOUS CONTRAST FOR MRI

Your physician has referred you to our facility for magnetic examination. In certain cases, IV contrast is used to enhance the images and provide better information. This medication is injected into a vein and highlights the structures of interest. This medication has been approved by the Food and Drug Administration as being safe and effective.

As with all medications, certain side effects and complications are possible. The injected contrast rarely causes headache, nausea or vomiting. Some laboratory blood tests in patients with anemia or other blood diseases may be temporarily altered by this medication. No serious reactions have been demonstrated.

The technologist performing your MRI exam will discuss this with you beforehand and will be glad to answer your questions. In particular, you should let them know if you are pregnant, breast feeding, or if you have anemia or any disease that affects blood cells.

I attest that all above information is correct to the best of my knowledge. I read and understand the contents of this form and have had the opportunity to ask questions regarding the information on this form and regarding the MRI procedure that I am about to undergo. I also give my consent for IV contrast to be used for my MRI exam if my physician had requested that it be used.

PATIENT SIGNATURE _____ **DATE** _____

PARENT/GUARDIAN SIGNATURE _____ **DATE** _____

FORM REVIEWED BY: _____ **DATE** _____