



MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date _____ Exam _____

Referring Physician _____ Reason / Symptoms _____

YES NO / PLEASE CHECK THE APPROPRIATE BOX

- Have you had any prior surgeries or operations? If yes, please list date and type:
 Date _____ Type _____
 Date _____ Type _____
 Date _____ Type _____
- Have you had other imaging exams (CT, Xray, Ultrasound, Nuc. Med., MRI)? If yes, please list:
 Date _____ Type _____ Where _____
 Date _____ Type _____ Where _____
 Date _____ Type _____ Where _____
 Date _____ Type _____ Where _____
- Have you had any problems during a previous MRI exam? If yes, please describe: _____
- Have you had an eye injury involving a metallic object or fragment? (e.g. metal slivers, shavings, foreign objects, etc.) If yes, describe: _____
- Have you had any injury involving a metallic object? (e.g. BB, bullet, shrapnel, etc.)
 If yes, describe: _____
- Have you taken a sedative today prior to this exam? If so, please list: _____
- Are you allergic to any Medications? If yes, please list: _____
- Do you have a history of (If yes, please circle): asthma, allergic reaction, respiratory disease or reaction to any imaging contrast agent/dye used for an MRI, CT, or Xray exam?
- Do you have a history of (If yes, please circle): anemia, any blood disorder, prior renal (kidney) disease or seizures. Describe: _____

Please turn the page over and complete the check list for any items that could cause issues if not identified prior to entering the MR scanning room. The technologist will discuss anything you have marked "Yes".

	<p>WARNING: Certain implants, devices or objects may be hazardous to you and / or may interfere with the MRI procedure. Do not enter the MRI 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 MRI magnet is ALWAYS on.</p> <p>IMPORTANT INSTRUCTIONS: Before entering the MR Environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beepers, cell phone, eye glasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paper clips, monet clips, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal decoration, threads or fasteners.</p>
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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.

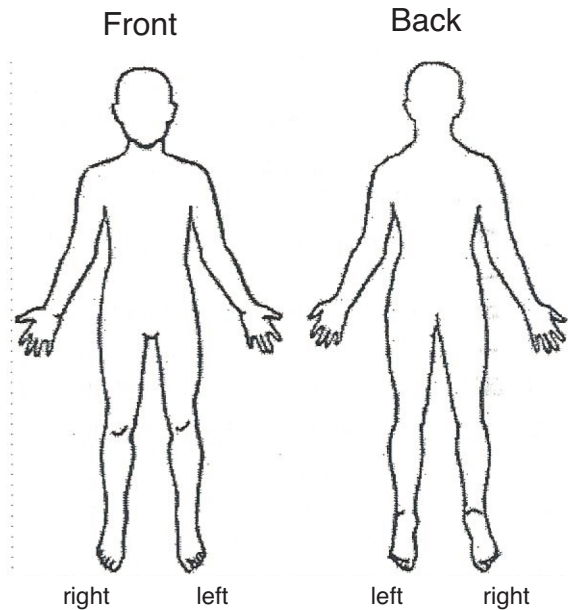
Please indicate if you have any of the following:

Yes No

- Aneurysm clip(s)
- Cardiac Pacemaker
- Implanted Cardioverter Defibrillator (ICD)
- Electronic implant or device
- Magnetically-activated implant or device
- Neurostimulation system
- Spinal Cord Stimulator
- Internal Electrodes or wires
- Bone growth / bone fusion stimulator
- Cochlear, otologic or other ear implant
- Insulin or other infusion pump
- Implanted drug infusion device
- Any type of prosthesis (eye, penile, etc.)
- Heart Valve prosthesis
- Eyelid spring or wire
- Artificial or prosthetic limb
- Metallic stent, filter or coil
- Shunt (spinal or intraventricular)
- Vascular access port and/or catheter
- Radiation seeds or implants
- Medication patch (Nicotine, Nitroglycerine)
- Any metallic fragment or foreign body
- Wire mesh implant
- Tissue expander (ie. Breast)
- Surgical staples, clips or metallic sutures
- Joint replacement (hip, knee, etc.)
- Bone/joint pin, screw,nail, wire, plate, etc.
- IUD, diaphragm or pessary
- Dentures or partial plates
- Tattoo or permanent make-up
- Body piercing jewelry
- Hearing Aid
- Other implant
- Breathing problem or motion disorder
- Claustrophobia

Please consult the MRI technologist or Radiologist if you have any questions or concerns BEFORE you enter the MR room.

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



I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form. I've had the opportunity to ask questions regarding the information on this form and regarding the MRI procedure that I am about to have.

Signature of person completing form _____ Date _____

Form completed by: Patient Relative Nurse _____
 Print Name and Relationship to Patient

Form Information Reviewed By: Technologist Nurse Radiologist Other _____

 Print Name

 Signature