MAGNETIC RESONANCE IMAGING (MRI) PROCEDURE SCREENING FORM

Date ______/_______/_________

Name ____ Age______ Height________ Weight________
Last First MI

Date of birth ______/______/______ ☐ Male ☐ Female Body part being examined ____________________
Month Day Year

Address ____ Telephone # (work) ( ) ________-_________

City ____ Telephone # (home) ( ) ________-_________

State__________________ Zip Code______________

Reason for MRI and/or symptoms ____

Referring physician_____________________________ Phone # ( ) ______________-_____________

1. Have you had any prior surgeries of any kind? If yes, please indicate type of surgery: No ☐ Yes ☐

Date _______/______/_________ Type of surgery____

Date _______/______/_________ Type of surgery____

Date _______/______/_________ Type of surgery____

Date _______/______/_________ Type of surgery____

2. Have you had prior diagnostic imaging or exams (MRI, CT, Ultrasound, X-ray, etc.)?
If yes, please list:

	Body part	Date	Facility
MRI	______________________________	_____/_____/______	____________________________
CT	______________________________	_____/_____/______	____________________________
XRAY	______________________________	_____/_____/______	____________________________
Ultrasound	______________________________	_____/_____/______	____________________________

3. Have you experienced any problem related to a previous MRI procedure? No ☐ Yes ☐
If yes, please describe: ____
4. Have you had any injury to the eye involving a metal object or fragment? (metal slivers, shavings, etc.) No ☐ Yes ☐
If yes, please describe: ____
5. Have you ever been injured by a metallic object? (BB, bullet, shrapnel, etc.) No ☐ Yes ☐
If yes, please describe: ____
6. Are you currently taking or have you taken any medication or drug? No ☐ Yes ☐
7. Are you allergic to any medication?
If yes, please list: ____ No ☐ Yes ☐
8. Do you have asthma, allergic reaction, respiratory disease, or reaction to contrast medium or dye used in CT, MRI, or XRAY exam? No ☐ Yes ☐
9. Do you have anemia or any disease that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, or renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, history of diabetes, or seizures? No ☐ Yes ☐
If yes, please describe: ____

FEMALE PATIENTS:

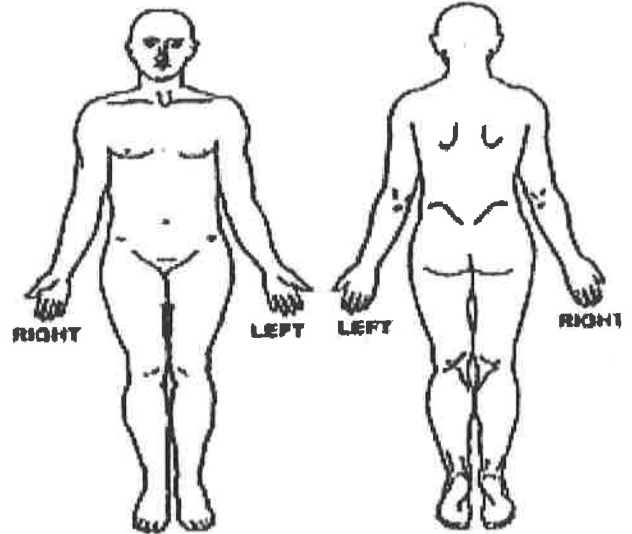
10. Date of last menstrual period: _______/_______/_________ Post-menopausal ? No ☐ Yes ☐
11. Are you pregnant or experiencing a late menstrual period? No ☐ Yes ☐
12. Are you taking oral birth control, receiving hormonal treatments, or have an IUD? No ☐ Yes ☐

WARNING: Certain implants, devices, or objects may be hazardous to you and/ or may interfere with the MR procedure. DO NOT ENTER the MR room if you have any questions or concerns regarding an implant, device, or object. Consult the MRI technologist BEFORE entering the MRI room. The MR magnet is ALWAYS on.

Please indicate if you have any of the following:

YES	NO	Aneurysm clips
YES	NO	Cardiac pacemaker
YES	NO	Implanted cardioverter defibrillator
YES	NO	Electronic implant or device
YES	NO	Magnetically activated implant or device
YES	NO	Neurostimulation system
YES	NO	Spinal cord stimulator
YES	NO	Bone growth/ bone fusion stimulator
YES	NO	Internal electrodes or wires
YES	NO	Cochlear, otologic, or other ear implant
YES	NO	Insulin or other infusion pump
YES	NO	Implanted drug infusion device
YES	NO	Joint replacement (hip, knee, shoulder, etc.)
YES	NO	Artificial or prosthetic limb
YES	NO	Heart valve prosthesis
YES	NO	Any type of prosthesis (eye, penile, etc.)
YES	NO	Bone/ joint pin, screw, nail, wire, plate, etc.
YES	NO	Surgical staples, clips, or metallic sutures
YES	NO	Any metallic fragment (BB, bullets, shrapnel)
YES	NO	Wire mesh implant
YES	NO	Metallic stent, filter, or coil
YES	NO	Tissue expander (e.g. breast)
YES	NO	Eyelid spring or wire
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 (nicotine, nitroglycerine)
YES	NO	IUD, diaphragm, or pessary
YES	NO	Dentures or partial plate
YES	NO	Tattoo or permanent makeup
YES	NO	Body piercing jewelry
YES	NO	Hearing aid (remove before entering MR)
YES	NO	Other implant________________________
YES	NO	Breathing problem or motion disorder
YES	NO	Claustrophobia

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



IMPORTANT INSTRUCTIONS

Before entering the MR room, you must remove all metallic objects including:

Hearing aids, dentures, partial plates, keys, cell phones, eyeglasses, hair pins, barrettes, jewelry, body piercings, watch, safety pins, money clip, credit cards, magnetic strip cards, coins, pens, pocket knives, nail clippers, tools, clothing with metal fasteners and clothes with metal threads and beads.

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

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: ______________________________ Date ___/___/_____

Form completed by: Patient Other ______________________________ ______________
Print Name Relationship

Form information reviewed by: ______________________________ ______________________
Print Name Signature