

# **MAGNETIC RESONANCE IMAGING (MRI) PROCEDURE SCREENING FORM**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name: \_\_\_\_\_  
Last First MI

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Male  Female Body part being examined \_\_\_\_\_

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? No  Yes   
If yes, please list: \_\_\_\_\_

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: \_\_\_\_\_

## FEMALEPATIENTS:

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

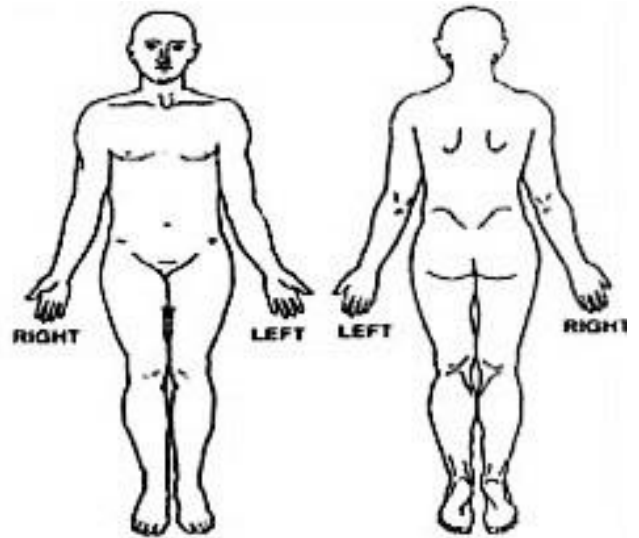


**WARNING:** Certain implants, devices, or objects may be hazardous to you and/ or may interfere with the MR procedure. **DO NOT ENTER** the MR room if you have any questions or concerns regarding an implant, device, or object. Consult the MRI technologist **BEFORE** entering the MRI room. The MR magnet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