MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date _____ Patient Number _____

Name _____ Age _____ Height _____ Weight _____
Last name First name Middle Initial

1. Have you ever been injured by a metallic or foreign object to eye/body (e.g., BB, bullet, shrapnel)? ☐No ☐Yes
2. Are you currently taking medication for pain, or blood pressure, or blood thinners? ☐No ☐Yes
3. Do you have a history of renal / kidney disease? ☐No ☐Yes
4. During a Diagnostic study, have you ever had a reaction to contrast of any kind?
   If Yes, please describe _____ ☐No ☐Yes

Please indicate if you have any of the following:

☐Yes ☐No Implanted cardioverter defibrillator (ICD)
☐Yes ☐No Cardiac pacemaker
☐Yes ☐No Electronic implant or device
☐Yes ☐No Aneurysm clip(s)
☐Yes ☐No Neurostimulation system
☐Yes ☐No Spinal cord stimulator
☐Yes ☐No Internal electrodes or wires
☐Yes ☐No Heart valve prosthesis
☐Yes ☐No Vascular access port and/or catheter
☐Yes ☐No Medical shunt
☐Yes ☐No Metallic stent, filter or coil
☐Yes ☐No Patch for pain, nicotine, nitro, etc.
☐Yes ☐No Any metallic fragment or foreign body
☐Yes ☐No Tissue expander (e.g., breast)
☐Yes ☐No Surgical staples, clips or metallic sutures
☐Yes ☐No Wire mesh implant, plate, screws, pins.
☐Yes ☐No Spinal fusion or orthopedic hardware
_____

☐Yes ☐No Eyelid spring or wire or weight
☐Yes ☐No Implanted drug infusion device
☐Yes ☐No Cochlear, otologic, or other ear implant
☐Yes ☐No Hearing aid *(Remove before entering MR)*
☐Yes ☐No IUD, diaphragm, pessary
☐Yes ☐No Body piercing jewelry
☐Yes ☐No Penile implant
☐Yes ☐No Other implant _____
☐Yes ☐No Are you pregnant or late period
☐Yes ☐No Are you currently breast feeding?

Reason for scan: _____
_____

Are you experiencing radiating numbness/tingling or pain?
If so where? _____
_____

Past surgeries related to today's scan _____
_____

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. Do not enter the MR system room or MR environment if you have any question or concern 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.

I attest that the above information is correct to the best of my knowledge. I have read and understand the entire contents of this form and have had the opportunity to ask questions regarding the information on this form.

Signature of Person Completing Form_____Date_____

Information Review By_____MR Technologist