



MAGNETIC RESONANCE IMAGING SCREENING FORM

ALL PATIENTS TO HAVE COMPLETED PRIOR TO HAVING AN MRI.

PLEASE CHECK YES OR NO IF YOU HAVE ANY OF THE FOLLOWING:

INPATIENTS: PATIENT/FAMILY OR PHYSICIAN TO COMPLETE PRIOR TO PATIENT BEING TRANSPORTED TO THE MRI DEPARTMENT.

NEW SCREENING FOR EACH MRI DONE THAT IS DATED ON DIFFERENT DAY. PLEASE ASSESS PATIENT IF MEDICATION IS NEEDED FOR
CLAUSTROPHOBIA OR PAIN BEFORE PATIENT COMES DOWN TO MRI. EXAMS COULD LAST UP TO 30 MINUTES AND PATIENT HAS TO BE
ABLE TO HOLD STILL.

PATIENT: _____ HEIGHT: _____ WEIGHT: _____ DOB: _____

HAS PATIENT EVER HAD A MRI PROCEDURE? YES DATE: ____/____/____ NO

SYMPTOMS: _____

**WARNING: CERTAIN IMPLANTS, DEVICES, OR OBJECTS MAY BE HAZARDOUS TO YOU OR INTERFERE WITH TEST!
IF YES IS MARKED (MOST IMPLANTS WILL NEED SURGICAL REPORT OR IDENTIFICATION CARD!)**

- YES NO CARDIAC PACEMAKER
- YES NO CARDIOVERTER DEFIBRILLATOR (ICD)
- YES NO ANEURYSM CLIPS
- YES NO NEUROSTIMULATOR
- YES NO BONE STIMULATOR
- YES NO INTERNAL ELECTRODES OR WIRES
- YES NO HEART VALVES
- YES NO STENTS, FILTERS, COILS (DATE OF IMPLANT) _____
- YES NO IMPLANTED MUSCLE STIMULATION DEVICES (TENS, UNIT, ETC)
- YES NO COCHLEAR, OTOLOGIC, OR OTHER EAR IMPLANT
- YES NO INTRAOCULAR LENS
- YES NO ANY TYPE OF PROSTHESIS (EYE, PENILE, ETC)
- YES NO ARTIFICIAL OR PROSTHETIC LIMB
- YES NO EYELID SPRING, WEIGHT OR WIRE
- YES NO VENTRICULOPERITONEAL SHUNT
- YES NO PROGRAMMABLE SHUNT
- YES NO PILLCAM DATE _____
- YES NO CAROTID ARTERY VASCULAR CLAMP (POPPEL-BLAYLOCK)
- YES NO TISSUE EXPANDERS (BREAST)
- YES NO RECENT COLONOSCOPY DATE _____
- YES NO ACTIPATCH-DRUG DELIVERY PATCH
- YES NO ANKLE MONITOR
- YES NO IMPLANTED INSULIN OR OTHER INFUSION PUMPS
- YES NO MAGNETICALLY ACTIVATED IMPLANT OR DEVICE
- YES NO MEDICATION PATCH (ALUMINUM FOIL BACKING)
- YES NO JOINT REPLACEMENT (HIP, KNEE, ETC.)
- YES NO IUD, DIAPHRAGM OR PESSARY (METAL)
- YES NO DENTURES OR PARTIAL PLATES, HEARING AIDS
- YES NO TATTOO OR PERMANENT MAKEUP
- YES NO BODY PIERCING JEWELRY (REMOVE BEFORE ENTERING MRI)
- YES NO BULLETS, SHRAPNEL, PELLETS, BB'S
- YES NO EVER WORKED AT HOME OR ON THE JOB WITH METAL
IN LIFETIME. EX: WELDING OR GRINDING
- YES NO INJURY TO EYE WITH METAL.
- YES NO CLAUSTROPHOBIA

ADDITIONAL INPATIENT INFORMATION

- YES NO SURGICAL CLIPS, FASTENERS, STAPLES
- YES NO SWAN-GANZ
- YES NO THERMODILUTION CATHETER
- YES NO INTRACRANIAL PRESSURE MONITOR (ICP)
- YES NO COOL GUARD 3000
- YES NO THERMOREGULATION SYSTEM
- YES NO REINFORCED E.T. TUBE (BLUE COIL)
- YES NO ENDO-TRACHEAL
- YES NO TEMPERATURE GAUGE FOLEY
- YES NO HALO SYSTEM
- YES NO WOUND VAC
- YES NO INTRASPINAL CATHETERS
- YES NO MONITORED (TELEMETRY PATIENT)
- YES NO ON A VENT

ALL OUTPATIENTS AND INPATIENTS

- YES NO TREMORS (CANNOT LIE STILL)
- YES NO UNABLE TO LIE FLAT
- YES NO OXYGEN LITERS _____
- YES NO LATEX ALLERGY
- YES NO DIABETIC
- YES NO RENAL FAILURE
- YES NO CANCER (TYPE) _____
- YES NO SICKLE CELL ANEMIA
- YES NO LIVER DISEASE
- YES NO SEIZURES
- YES NO HEART DISEASE
- YES NO RESPIRATORY PROBLEMS
- YES NO PREGNANT
- YES NO BREAST FEEDING

PLEASE LIST ANY SURGERIES PATIENT HAS HAD: _____

I ATTEST THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE:

PATIENT/GUARDIAN/NURSE OR PHYSICIAN TO SIGN:

SIGNATURE: _____ DATE: _____ TIME: _____

PLEASE FAX FORM TO 884683 BEFORE PROCEDURE PLEASE CALL 884792 IF ANY QUESTIONS