MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date _____/_____/_____

Name____ Age_____ Height _____ Weight _____
Last name First name Middle Initial

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1. Have you had **ANY** prior surgery or an operation (e.g., arthroscopy, endoscopy, etc.) of any kind?
   ☐ Yes ☐ No
   If yes, please indicate the type of surgery:
   Type of surgery____
   Type of surgery____
   Type of surgery____
   Type of surgery____
   Type of surgery____
2. Have you experienced any problem related to a previous MRI examination or MR procedure?
   ☐ Yes ☐ No
   If yes, please describe:____
3. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)?
   ☐ Yes ☐ No
   If yes, please describe:____
4. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)?
   ☐ Yes ☐ No
   If yes, please describe:____
5. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT or X-ray examination? ☐ Yes ☐ No
   If yes, please describe:____
6. Do you have anemia or any disease(s) that affects your blood or a history of renal (kidney) disease?
   ☐ Yes ☐ No
   If yes, please describe:____

For female patients:

7. Date of last menstrual period:___/___/___ Post menopausal? ☐ Yes ☐ No
8. Are you pregnant or experiencing a late menstrual period? ☐ Yes ☐ No
9. Are you currently breastfeeding? ☐ Yes ☐ No
10. Do you have an IUD, Diaphragm or Pessary? ☐ Yes ☐ No
11. Do you have tissue expanders (e.g. breast)? ☐ Yes ☐ No

	WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **<u>Do no enter</u>** the MR system room or MR environment if you have any questions 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.**

Please check Yes or No to the following questions:

☐ Yes ☐ No Aneurysm clip(s)
Cardiac pacemaker
Implanted cardioverter defibrillator (ICD)
Loop recorder
☐ Yes ☐ No Electronic implant or device
Magnetically-activated device
Neurostimulation system
Spinal cord stimulator
Internal electrodes or wires
Bone growth/bone fusion stimulator
☐ Yes ☐ No Cochlear, or other ear implant
☐ Yes ☐ No Insulin or other infusion pump
Implanted drug infusion device
☐ Yes ☐ No A type of prosthesis (eye, penile etc.)
☐ Yes ☐ No Heart valve prosthesis
☐ Yes ☐ No Eyelid spring or wire
☐ Yes ☐ No Artificial or prosthetic limb
☐ Yes ☐ No Metallic stent, filter, or coil
☐ 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 Any metallic fragment or foreign body
☐ Yes ☐ No Wire mesh implant
☐ Yes ☐ No Surgical staples, clips or sutures
☐ Yes ☐ No Joint replacement (hip, knee, etc.)
☐ Yes ☐ No Bone/joint pin, screw, nail, wire plate

☐ Yes ☐ No Are you wearing anything containing Copper or Silver scent
☐ Yes ☐ No Dentures or partial plates
☐ Yes ☐ No Tattoo or permanent makeup
☐ Yes ☐ No Body piercing jewelry
☐ Yes ☐ No Hearing aid
☐ Yes ☐ No Breathing problem or motion disorder
☐ Yes ☐ No Claustrophobia
☐ Yes ☐ No Parkinson's disease implant
☐ Yes ☐ No GI Camera (pill that you swallow)
(Remove before entering MR system room)
☐ Yes ☐ No Other implant____________________

!	**IMPORTANT INSTRUCTIONS**

Before entering the MR environment or MR system room, you must remove <u>all</u> metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic stip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

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.

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:____
Signature

Form Completed By: ☐ Patient ☐ Relative ☐ Nurse ________________________________
Print Name

Relationship to patient ______________________________ Contact Number: ______________________________

☐ MRI Technologist ________________________________