Touchstone
MEDICAL IMAGING

MRI Screening Form

PATIENT NAME:_____ **PATIENT ID#:**_____
LAST NAME **FIRST NAME** **MIDDLE**

DOB:_____ **SEX:**_____ **DATE OF SERVICE:**_____

EXAM:_____

What is your weight? _____ **What is your height?**_____

Do you have any of the following?

☐ Yes ☐ No **Do you have a Pacemaker or Defibrillator? *** If yes, please notify our staff immediately. You may not be able to have an MRI exam***__**

☐ Yes ☐ No Are you wearing a drug patch? If yes, explain:_____
☐ Yes ☐ No Heart surgery/Heart Valve? If yes, explain:_____
☐ Yes ☐ No Brain surgery/**Brain Aneurysm Clip?** If yes, explain:_____
☐ Yes ☐ No Are you being treated for chronic renal (kidney) disease or on dialysis?
☐ Yes ☐ No Shunts/Stents/Intravascular Coil?:_____
☐ Yes ☐ No Do you have dentures - **Including Magnetic Dentures**, retainers, or dental implants?
☐ Yes ☐ No Ear surgery/**Cochlear Implants**/Hearing Aids?:_____
☐ Yes ☐ No Medication Pump/Drug Infusion/Insulin?:_____
☐ Yes ☐ No Tens Unit/Neurostimulator/Biostimulator?:_____
☐ Yes ☐ No Sickle Cell Anemia? _____
☐ Yes ☐ No Have you had metal removed from your eyes?_____
☐ Yes ☐ No Permanent Eye Makeup? _____
☐ Yes ☐ No Do you have a prosthesis?_____
☐ Yes ☐ No Are you pregnant? _____
☐ Yes ☐ No Any history of **Cancer**? _____
Please list or comment on any other metal you may have in your body:_____

Clinical Information

Allergies: Medications_____ Food_____
Existing Conditions: Heart Diabetes Asthma Kidney/Dialysis
Stroke Cancer Tumor Major Trauma
Previous Surgeries: Brain Spine Joint Abdomen
Describe the problem you are having _____
Have you had surgery in the area of the problem? _____
Have you had a previous scan of the area we are scanning today? Yes_____ No _____
If yes: Where? _____ Date:_____

CONSENT: I have answered all the questions to the best of my knowledge and understand the information presented to me. I have also informed the technologist that I am not pregnant at this time.

Parent/Legal Guardian Signuature: _____**Date:**_____

Reviewing Technologist Signature: _____**Date:**_____
INTERNAL USE ONLY: Creatinine level_____ **(Normal level: 0.5 - 1.5)**

GFR:_____**IV:**_____**Guage:**_____**CC:**_____

 # Of Punctures: _____ **Coverage by:**_____

Technologist:_____ **Lot:**_____**Exp:**_____