

MRI Screening Form

First Name: _____ M.I. _____ Last Name: _____

DOB: _____ Male / Female Height: _____ Weight: _____ Physician: _____

Describe your symptoms: _____

How long have you had these symptoms? _____ How often: _____

List Surgeries: _____

List prior imaging studies that pertain to this problem: _____

Have you ever had a reaction to MRI contrast/dye? _____

List any allergies: _____

WARNING: Certain implants, devices, or objects may be hazardous to your safety and may interfere with the MRI. **DO NOT ENTER** the MRI room if you have any question or concern regarding an implant, device or object until consulting with the MRI Technologist. **The MRI magnet is ALWAYS on.** The information requested below is very important. Please answer all questions as thoroughly as possible.

Please indicate yes or no if you have any of the following:

<input type="radio"/> No <input type="radio"/> Yes Aneurysm clip(s)	<input type="radio"/> No <input type="radio"/> Yes PICC line, port, catheter
<input type="radio"/> No <input type="radio"/> Yes Cardiac Pacemaker	<input type="radio"/> No <input type="radio"/> Yes Shunt, Stent, Intravascular Coil
<input type="radio"/> No <input type="radio"/> Yes Implant cardioverter defibrillator (ICD)	<input type="radio"/> No <input type="radio"/> Yes Radiation seeds or implants
<input type="radio"/> No <input type="radio"/> Yes Electronic implant or device	<input type="radio"/> No <input type="radio"/> Yes Metal in eyes/Injury to eyes (metallic slivers, shavings)
<input type="radio"/> No <input type="radio"/> Yes Magnetically-activated implant or device	<input type="radio"/> No <input type="radio"/> Yes Metal removed from eye(s)
<input type="radio"/> No <input type="radio"/> Yes Tens Unit/Neurostimulator/Bio stimulator	<input type="radio"/> No <input type="radio"/> Yes Injury by a metallic fragment (bullet, BB, shrapnel)
<input type="radio"/> No <input type="radio"/> Yes Spinal cord stimulator	<input type="radio"/> No <input type="radio"/> Yes Wire mesh implants
<input type="radio"/> No <input type="radio"/> Yes Tissue expander (e.g. breast)	<input type="radio"/> No <input type="radio"/> Yes Internal electrodes or wires
<input type="radio"/> No <input type="radio"/> Yes Surgical staples, clips or metallic sutures	<input type="radio"/> No <input type="radio"/> Yes Bone growth/Bone fusion stimulator
<input type="radio"/> No <input type="radio"/> Yes Bone/joint pin, screw, nail, wire, plate, rod	<input type="radio"/> No <input type="radio"/> Yes IUD, diaphragm, pessary
<input type="radio"/> No <input type="radio"/> Yes Insulin, pain or other infusion pump	<input type="radio"/> No <input type="radio"/> Yes Dentures/partial/retainer
<input type="radio"/> No <input type="radio"/> Yes Any patch (medication, pain, nicotine, nitroglycerin)	<input type="radio"/> No <input type="radio"/> Yes Tattoo/permanent makeup/body piercing
<input type="radio"/> No <input type="radio"/> Yes Any type of prosthesis or implant (eye, penile)	<input type="radio"/> No <input type="radio"/> Yes Eyelid spring or wire
<input type="radio"/> No <input type="radio"/> Yes Artificial or prosthetic limb	<input type="radio"/> No <input type="radio"/> Yes Hearing aid (remove before entering MRI room)
<input type="radio"/> No <input type="radio"/> Yes Heart valve prosthesis	<input type="radio"/> No <input type="radio"/> Yes Cochlear, otologic, or other ear implant
<input type="radio"/> No <input type="radio"/> Yes Acute renal insufficiency due to hepato-renal syndrome	<input type="radio"/> No <input type="radio"/> Yes In perioperative liver transplant period
<input type="radio"/> No <input type="radio"/> Yes Acute or chronic renal disease	<input type="radio"/> No <input type="radio"/> Yes Any prior transplants (liver/kidney/other)
<input type="radio"/> No <input type="radio"/> Yes Dialysis	<input type="radio"/> No <input type="radio"/> Yes Hepatic (liver) Disease
<input type="radio"/> No <input type="radio"/> Yes Diabetes	
<input type="radio"/> No <input type="radio"/> Yes Blood-related disorder (Anemia, Leukemia, Sickle Cell)	
If answered "Yes" to Anemia, have you received an injection of Ferumoxytol	<input type="radio"/> No <input type="radio"/> Yes If Yes, when _____
<input type="radio"/> No <input type="radio"/> Yes Multiple Sclerosis	<input type="radio"/> No <input type="radio"/> Yes Breathing problems or motion disorder
<input type="radio"/> No <input type="radio"/> Yes Hypertension (high blood pressure)	<input type="radio"/> No <input type="radio"/> Yes Seizures
<input type="radio"/> No <input type="radio"/> Yes Cancer If yes, where _____	<input type="radio"/> No <input type="radio"/> Yes Have you taken oral sedating medication for this MRI?
<input type="radio"/> No <input type="radio"/> Yes Back or Neck Surgery	<input type="radio"/> No <input type="radio"/> Yes Joint replacement (hip, knee, shoulder)
<input type="radio"/> No <input type="radio"/> Yes Currently Breast Feeding	<input type="radio"/> No <input type="radio"/> Yes <input type="radio"/> Maybe Pregnant

WARNING: Before entering the MRI room, YOU MUST REMOVE ALL metallic objects including, but not limited to, the following: hearing aids, dentures, partial plates, keys, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercings, watch, safety pins, money clip, credit/bank/magnetic strip cards, coins, pens, pocket knife, handgun, nail clippers, tools, clothing with metal fasteners or metallic threads. You will be asked to wear MRI safe earplugs or headphones during the exam.

CONSENT: I have informed the technologist that **I do not have any metallic devices** such as a pacemaker, implant, cerebral aneurysm clips in my body or metallic foreign bodies in my eyes. I further affirm the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions. I have also informed the technologist that **I am not pregnant at this time.**

Signature of Person Completing Form: _____ Date: _____

Relationship to Patient: Self Spouse Guardian

Technologist who reviewed safety screening with patient: _____ Date: _____

(Print first and last name)