Northeast Hospitals

# MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

PATIENT NAME: ________________________________________ Date of Birth _________/_________/________
Mo. Day Yr.

Height:__________ Weight: __________

Have you had a prior diagnostic imaging study or examination relating to the symptoms you are experiencing?
If yes, please list:

| | Yes | Date | Where |
|---|---|---|---|
| MRI | ______________________ | _______/______/______ | ______________________ |
| CT/CAT Scan | ______________________ | _______/______/______ | ______________________ |
| X-ray | ______________________ | _______/______/______ | ______________________ |
| Ultrasound | ______________________ | _______/______/______ | ______________________ |
| Nuclear Medicine | ______________________ | _______/______/______ | ______________________ |
| PET Scan | ______________________ | _______/______/______ | ______________________ |
| Other | | _______/______/______ | |

**Please check all that apply**

| No | Yes | Question | |
|---|---|---|---|
| ☐No | ☐Yes | Have you ever had cancer? | Type: |
| ☐No | ☐Yes | Have you ever had chemotherapy? | When: |
| ☐No | ☐Yes | Have you ever had radiation therapy? | When: |
| ☐No | ☐Yes | Have you ever had diabetes? | Type I ☐ Type II ☐ |
| ☐No | ☐Yes | Are you pregnant? | |
| ☐No | ☐Yes | Are you breast feeding? | |
| ☐No | ☐Yes | Are you over 60 years of age? | |
| ☐No | ☐Yes | Do you have hypertension (high blood pressure)? | |
| ☐No | ☐Yes | Are you receiving dialysis? | Peritoneal Dialysis_______ Hemodialysis _________ |
| ☐No | ☐Yes | Do you have a history of renal disease? (including one kidney, kidney transplant, kidney tumor or kidney mass) | |
| ☐No | ☐Yes | Are you in acute renal failure/insufficiency? | |

**HEAD PROCEDURES:** *(check all symptoms you may have)*

Headaches ☐ Seizures ☐ Migraines ☐ High Blood Pressure ☐

Dizziness ☐ Pain ☐ Weakness ☐ Loss of Balance ☐

Difficulty Walking ☐ Numbness/Tingling ☐

Decreased Hearing Right ☐ Left ☐ Decreased Vision Right ☐ Left ☐

Ringing in Ear Right ☐ Left ☐

How long have you experienced the above symptoms? ________________________________

How severe are the symptoms? Mild ☐ Moderate ☐ Severe ☐

Have you ever had surgery of the area being examined today? No☐ Yes☐

If yes, date of surgery : What Type?

**Additional comments or notes:**

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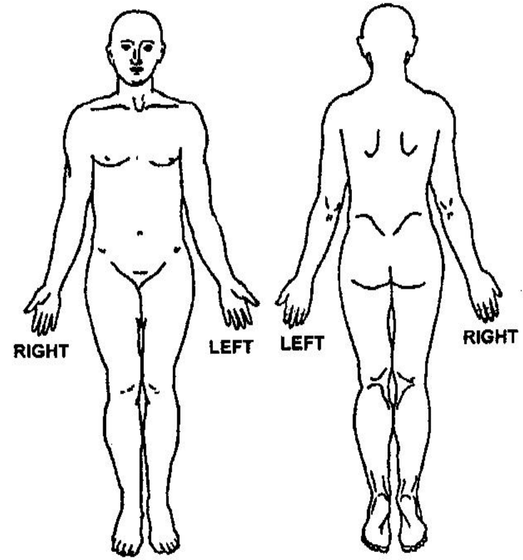
Patient Identification

**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). 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.

Please Indicate if you have the Following

- ☐ Yes ☐ No Aneurysm clip(s)
- ☐ Yes ☐ No Cardiac pacemaker
- ☐ Yes ☐ No Implanted cardioverter defibrillator (ICD)
- ☐ Yes ☐ No Electronic implant or device
- ☐ Yes ☐ No Magnetically-activated implant or device
- ☐ Yes ☐ No Neurostimulation system
- ☐ Yes ☐ No Spinal cord stimulator
- ☐ Yes ☐ No Internal electrodes or wires
- ☐ Yes ☐ No Bone growth/bone fusion stimulator
- ☐ Yes ☐ No Cochlear, otologic, or other ear implant
- ☐ Yes ☐ No Insulin or other infusion pump
- ☐ Yes ☐ No Implanted drug infusion device
- ☐ Yes ☐ No Any 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 themodilutiori catheter
- ☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine)
- ☐ Yes ☐ No Any metallic fragment or foreign body
- ☐ Yes ☐ No Wire mesh implant
- ☐ Yes ☐ No Tissue expander (e.g., breast)
- ☐ Yes ☐ No Surgical staples, clips, or metallic sutures
- ☐ Yes ☐ No Joint replacement (hip, knee, etc.)
- ☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate, etc
- ☐ Yes ☐ No IUD, diaphragm, or pessary
- ☐ Yes ☐ No Dentures or partial plates
- ☐ Yes ☐ No Tattoo or permanent makeup
- ☐ Yes ☐ No Body piercing jewelry
- ☐ Yes ☐ No Hearing aid (Remove before entering MR system rm)
- ☐ Yes ☐ No Other implant ________________________
- ☐ Yes ☐ No Breathing problem or motion disorder
- ☐ Yes ☐ No Claustrophobia

**Please mark on the figure(s) below the location of any implant or metal inside of, or on, your body**



**IMPORTANT INSTRUCTIONS**

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eye glasses/glass case, hair pins, barrettes, jewelry, body piercing jewelry, watches, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip 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 questions or concerns 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.

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**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: ________________________________ Date _____/_____/_____

Form Completed By: ☐Patient ☐Nurse ☐Relative ________________________ ________________________

Print Name — Relationship to Patient

Form Information Reviewed By: ☐MRI Technologist ☐Nurse ☐Radiologist ☐Other ____________

________________________________ ________________________________

Reviewer Print Name — Reviewer Signature

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