

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

<input type="checkbox"/> No	<input type="checkbox"/> Yes	Have you ever had cancer?	Type:
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Have you ever had chemotherapy?	When:
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Have you ever had radiation therapy?	When:
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Have you ever had diabetes?	Type I <input type="checkbox"/> Type II <input type="checkbox"/>
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Are you pregnant?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Are you breast feeding?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Are you over 60 years of age?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Do you have hypertension (high blood pressure)?	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Are you receiving dialysis?	Peritoneal Dialysis _____ Hemodialysis _____
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Do you have a history of renal disease? (including one kidney, kidney transplant, kidney tumor or kidney mass)	
<input type="checkbox"/> No	<input type="checkbox"/> Yes	Are you in acute renal failure/insufficiency?	

SPINE PROCEDURES: *(Check all symptoms you may have)*

Cervical (upper) Spine/Thoracic (middle) Spine/Lumbar (lower) Spine

 Pain: Right Left Numbness/Tingling: Right Left

 Weakness: Right Left Bowel or bladder Incontinence: No Yes

Other Symptoms? _____

How long have you experienced the above symptoms? _____

 Are the symptoms you are experiencing the result of an injury or accident? No Yes

If yes please describe: _____

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

If yes, date of surgery : _____ What type? _____

Additional Comments or Notes:

Patient Identification

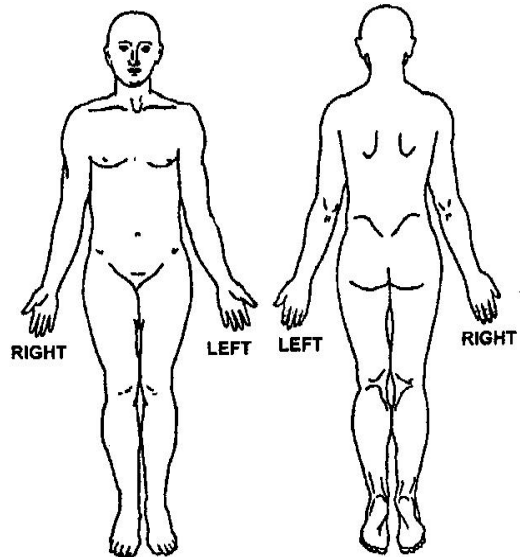


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). Do not enter the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. 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 themodilutori 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.

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