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	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?	

ABDOMINAL/MISCELLANEOUS: *(Check all symptoms you may have)*

Area to be examined today:

Please describe symptoms: Pain ☐ Swelling ☐ Bloating ☐
Other symptoms:

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

If yes please describe:

How long have you experienced the above symptoms?

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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Form #: CC355

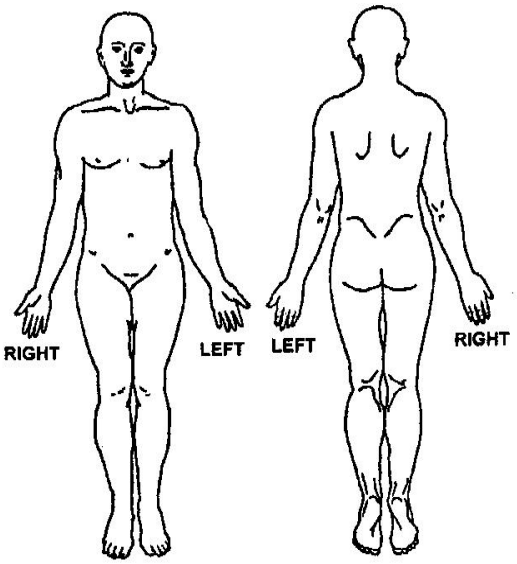
Patient Identification

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 (lCD)
- ☐ 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.

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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