

MAGNETIC RESONANCE IMAGING (MRI) SCREENING FORM

PATIENT INFORMATION									
Name:			Date of Birth:		Weight:		Physician:		
Exam:			Symptoms:						
PATIENT SCREENING								YES	NO
Have you <u>ever</u> had an injury to the eye involving a metallic object (e.g. metallic slivers, grinding, shrapnel etc)									
<ul style="list-style-type: none"> If YES, orbit x-rays must be done and read by a radiologist prior to scheduling an MRI unless assured by the physician that all metal was removed following the injury. (Completed? <input type="checkbox"/>Yes <input type="checkbox"/>No) 									
Do you experience claustrophobia in small spaces or have difficulty lying flat and holding still for 30 minutes?									
<ul style="list-style-type: none"> If needed, contact your doctor to arrange medication before the day of the scan. (Arranged? <input type="checkbox"/>Yes <input type="checkbox"/>No) 									
<ul style="list-style-type: none"> If you were prescribed medications for this exam, indicate meds here: 									
(Female patients): Are you pregnant or suspect that you may be pregnant?									
<ul style="list-style-type: none"> If you are breastfeeding, please inform the technologist. 									
Mark Yes to any that apply		Y	N	Y		N	Y		N
On Dialysis			Severe or end-stage CKD			Acute Kidney Injury			
Kidney Transplant			Single Kidney			History of cancer with the kidneys			
History of CKD			History of Acute Kidney injury			Diabetes Mellitus			
Previous Reaction to MRI Contrast			Asthma						
List Any Allergies:									
If yes, and Group I or III contrast is likely to be used:			Creatinine:			eGFR:			
Date:									
Certain implants are hazardous and may prevent you from having an MRI. Any items answered "Yes" require written documentation to be reviewed and approved prior to scheduling or scanning.								YES	NO
<ul style="list-style-type: none"> Pacemaker or implanted wires (CURRENTLY NOT SCANNED AT THIS FACILITY) 									
<ul style="list-style-type: none"> Implanted cardioverter defibrillator (ICD) (CURRENTLY NOT SCANNED AT THIS FACILITY) 									
<ul style="list-style-type: none"> Brain Surgery? If yes what type: 									
Mark Y or N to any that apply		Y	N	Y		N	Y		N
Brain aneurysm clips or coils			Implanted neurostimulator			Implanted Sleep apnea device			
Inner/Middle ear device (cochlear)			Implanted device with a magnet			Linx or gastric reflux device			
CSF shunt with programmable valve			Implanted insulin pump			Implanted drug diffusion pump			
Breast Tissue Expander			Penile Implant			Carotid (neck) artery clamp			
Cardiac stents			Implanted Baskets			Implanted Coils or Filters			
Other implanted stents			Detached retina clip			Eye Spring			
Swallowed GI Pillcam (within 4 weeks)			Endoscopy (within last 3 months)			Colonoscopy (within last 3 months)			
Attached glucose monitor			Other devices on surface of skin			Parole Monitor (must remove)			
Artificial Joints or orthopedic pins			Hearing Aids (need to be removed)			Medication or Nicotine Patches			
Compression Sleeve (joint support)			Tattoos			Dentures, partials, or braces			
Odor resistant sport clothing			Clothing containing metal			Body Piercing jewelry			
Life Alert			Permanent Jewelry						
Any other implanted devices			IF yes please list:						
Any currently attached to your skin			IF yes please list:						
ATTESTATION									
I attest the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and the MRI procedure I am having.									
Signature of Patient (or Responsible Party):							Date: / /		
Interviewer's name:					Technologist's name:				