DESOTOIMAGING
SPECIALISTS

MRI PATIENT HISTORY AND SCREENING FORM

Name: _____ **Height:** _____ **Weight:** _____**Lbs./Kg Visit ID:**

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MRI scan. Do not enter the MRI environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist BEFORE entering the MRI environment. The MRI system is ALWAYS on.

Please indicate if you have any of the following:

Aneurysm clip	□ Yes □ No
Cardiac pacemaker	□ Yes □ No
Implanted cardiac defibrillator	□ Yes □ No
Electronic implant or device	□ Yes □ No
Neurostimulation system	□ Yes □ No
Internal electrodes or wires	□ Yes □ No
Bone growth/stimulation system	□ 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
Cardiac Stents	□ 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 or catheter	□ Yes □ No
Radiation seeds or implants	□ Yes □ No
Swan-Ganz or thermodilution catheter	□ Yes □ No
Medication Patch (nicotine, pain)	□ Yes □ No
Any metallic foreign body – especially eyes	□ 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
Body piercing jewelry	□ Yes □ No
Tattoos	□ Yes □ No
Hearing aid	□ Yes □ No
Breathing problem or motion disorder	□ Yes □ No

Other implant_____

Monitor of any kind (e.g. glucose) _____

Are you currently pregnant? □ Yes □ No Nursing? □ Yes □ No

Reason and/or symptoms for MRI today:

_____
_____
_____
_____

Have you ever worked with or around metal?

_____
_____

Please list any surgery you have had in the past on the area we are scanning:

_____
_____
_____

Do you currently have or have a history of any of the following? (circle)

Brain Aneurysm	Stroke	Seizures
High blood pressure	Diabetes	Cancer
Multiple Sclerosis	Kidney disease/failure	
Immune Deficiency	Contrast allergy	

******* For internal use only *******

Clariscan given: _____ ml

Bottle Size:_____ ml Discard amount: _____ml

Follow up date: _____

I attest that the above information is correct to the best of my knowledge. I read and understood the contents of this form and had the opportunity to ask questions regarding the information on this form and regarding the MRI exam.

Patient/Guardian _____ **Relationship**_____ **Date**_____

MRI technologist discussed screening form with patient prior to entry of room_____