MRI Safety Screening

Name:____ Date of Birth:_________________ Height:________

Referring Provider:___________________________________ Date of Exam:_________________ Weight:________

Do you have **ANY** of the following? Please answer **ALL** questions.

Yes No Cardiac pacemaker

Yes No Implanted cardioverter defibrillator (*ICD*)

Yes No Internal electrodes or wires

Yes No Heart valve prosthesis

Yes No Cardiac or vascular stent, filter, coil

Yes No Aneurysm clips

Yes No Neurostimulation system *(or past removal of one)*

Yes No Spinal cord stimulator

Yes No Shunt (*spinal or intraventricular*)

Yes No Bone growth or electronic fusion stimulator

Yes No Implanted drug infusion device

Yes No Tissue Expander (*e.g. breast expander*)

Yes No Any type of prosthesis (*eye, penile, limb, etc.*)

Yes No Pill cam capsule endoscopy device

Yes No Cochlear, otologic, other ear implants

Yes No Hearing aids (*must remove before entering MRI room*)

Yes No Eyelid spring or wire

Yes No Eye surgery (*cataracts, lens replacements, etc.*)

Yes No Injury to eye by metallic object

Yes No Metallic fragments or particles in eyes

Yes No Metallic fragments removed by a physician?

Yes No Any metal fragment, shrapnel, bullet, foreign body

Yes No Are you pregnant?

Yes No Myasthenia gravis? *(should not use MRI contrast if yes)*

Yes No Allergy or reaction to MR contrast *(gadolinium)*

Yes No Vascular access port

Yes No Swan-Ganz thermodilution catheter

Yes No Radiation seeds or implants

Yes No Medication Patch

Yes No IUD, diaphragm, pessary

Yes No Joint replacement (*e.g. hip, knee*)

Yes No Orthopedic pin, screw, plate, etc.

Yes No Surgical staples, clips, metallic sutures

Yes No Wire mesh implant

Yes No Any other implants not directly queried

Yes No Kidney disease or renal insufficiency

Yes No Diabetic, hypertension, liver disease

Yes No Breathing problems or motion disorder

Yes No Tattoo or permanent make-up (Minimum 2 weeks since date of tattooing before patient can be scanned)

Yes No Body piercing jewelry

Yes No Dentures or partial plates

Yes No Are you claustrophobic?

Staff Use Only:____________________________________

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IMPORTANT!!! - For your safety, you are required to change into the gown(s) provided for your exam.

Before entering the MR environment or MR system room, you must remove ALL metallic objects including, hearing aids, dentures, partial plates, keys, beepers, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clips, credit cards, bank cards, magnetic strip cards, coins, pens, pocketknife, nail clippers, tools.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and have had the opportunity to ask questions regarding the MR procedure that I am about to undergo.

Form Completed By: ______________________________ Signature: _______________________________

Relationship to Patient: ___________________________ Date: ___________________________________

Patient Initials _________ I have been given a copy of a gadolinium medication guide for my review.

Staff Use Only:
Reviewed By: Staff: _______________ Date: _______________ Staff: _______________ Date: _______________

PENRAD IMAGING

MRI Exam History

Patient Name: ______________________________ Date: ____________

Reason for MR exam (*symptoms and duration*): ______________________________

Are your symptoms related to an accident or injury? Yes No Date of Injury: ____________

Type of accident/injury______________________________

Is this a follow up prior to a previously diagnosed medical condition? Yes No

Please explain:______________________________

Have you had surgery **on the body part(s) being scanned today**? Yes No

Type of Surgery and approximate date: ______________________________

Surgeon: ____________________ Hospital or Surgical Facility: ____________________

Have you ever been diagnosed with cancer? Yes No

If yes, type of cancer:____________________ Year Diagnosed:__________ Known metastasis? Yes No

Circle treatment(s) and year of procedure(s): Surgery __________ Radiation __________ Chemo __________

List any other relevant medical conditions: ______________________________

List any medications you are currently taking: ______________________________

____

Drug allergies: ______________________________

Complete the section below applicable to today's MR procedure

MR Head:

Abnormal Imaging Study	Yes	No	Multiple Sclerosis	Yes	No
Headaches	Yes	No	Seizures	Yes	No
Head Trauma/Concussion	Yes	No	Mass, Tumor	Yes	No
Previously Diagnosed Stroke	Yes	No	Speech Problems	Yes	No
Weakness, Numbness	Yes	No	Difficulty Thinking	Yes	No
Dizziness, Balance Problems	Yes	No	Difficulty Walking	Yes	No
Facial Pain	Yes	No	Abnormal Labs	Yes	No
Hearing Problems	Yes	No	Vision Problems	Yes	No
Ear Pain	Right	Left	Double Vision	Yes	No
Ear Pressure	Right	Left	Blurred Vision	Right	Left
Hearing Loss	Right	Left	Vision Loss	Right	Left
Tinnitus/Ringing	Right	Left	Eye Pain	Right	Left

MR Spine (circle area involved):

Pain:	Neck	Right Arm	Left Arm	Back	Right Leg	Left Leg
Weakness:	Neck	Right Arm	Left Arm	Back	Right Leg	Left Leg
Numbness/Tingling:	Neck	Right Arm	Left Arm	Back	Right Leg	Left Leg

MR Joints or Limbs (circle any that apply):

Pain	Fall	Mass, Tumor, Lump
Swelling	Twisting Injury	Infection
Giving-out	Lifting/Carrying Heavy Object	Redness
Locking/Catching	Blunt Force Trauma	Open Wound

MR Throat, Chest, Abdomen, Pelvis:

Abnormal Imaging Study	Yes	No	Jaundice	Yes	No
Difficulty Swallowing	Yes	No	Diarrhea	Yes	No
Mass, Tumor, Lump	Yes	No	Constipation	Yes	No
Abnormal Labs	Yes	No	Nausea/Vomiting	Yes	No

Prior Exams: Have you had ANY previous radiology studies **on the body part(s) being scanned today**? Yes No

MRI Facility/Year:____________________ CT Facility/Year:____________________

MRI Facility/Year:____________________ CT Facility/Year:____________________

US Facility/Year:____________________ X-Ray Facility/Year:____________________