MR Safety Screening

Name: _____ Date of Birth: _____ Height: _____

Referring Provider: _____ Date of Exam: _____ Weight: _____

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

Yes No Cardiac pacemaker, defibrillator or other heart implant (***in place or removed***)

Yes No Heart prosthesis *(PFO/ASD closure device, Watchman)* or implanted cardiac recorder *(**loop recorder**)*

Yes No Neurostimulation system: Brain, spine, bladder, stomach, sleep apnea, vagus *(**in place or removed**)*

Yes No Colonoscopy, endoscopy or Pillcam endoscopy device (***within past 2 months***)

Yes No Joint replacement, pin, screw or plate ***Where?***_____.

Yes No Artificial or prosthetic limb, eye or penile implant. ***Where?*** _____.

Yes No Eye surgery: Cataract, Lens implant, glaucoma shunt, iSTENT, eyelid spring or eyelid weight ***Date***_____.

Yes No Injury to eye by metallic object or history of metal in your eyes ***When***?_____.

Yes No Any other metal foreign bodies *(Shrapnel, bullet, BB)* ***Where?*** _____.

Yes No Any other electronic or magnetically activated implants (***LINX band or other***) _____.

Yes No Aneurysm clips or embolization coils

Yes No Shunt (*Spinal or intraventricular*)

Yes No Tissue expander (*Breast expander,palate expander,other*)

Yes No Surgical staples, clips, metallic sutures

Yes No Wire mesh implant

Yes No Vascular access port

Yes No Insulin pump or other implanted drug infusion device

Yes No Cochlear, BAHA, otologic or other ear implants

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

Yes No Magnetic eyelashes or eyeliner

Yes No Spray on or powdered hair/scalp coloring

Yes No Copper containing garment, socks, underwear or brace

Yes No Are you claustrophobic?

Yes No Electronic monitoring equipment *(ankle monitor, other)*

Yes No Any stent, filter, coil or graft

Yes No Internal electrodes or wires

Yes No Bone growth or electronic fusion stimulator

Yes No Radiation seeds or implants

Yes No Currently pregnant

Yes No IUD, diaphragm, pessary

Yes No Medication patch/Constant glucose monitor

Yes No Breathing problems or motion disorder

Yes No Body piercing jewelry

Yes No Any tattoo or permanent make-up

Yes No Tattooed within the past 2 days

Yes No Dentures or partial plate

Yes No Other implants not queried_____

Staff Use Only:_____

Yes No Allergic reaction to MRI contrast?

Yes No Anaphylaxis/Severe reaction to *anything*

Yes No Asthma History

Yes No Recent history of kidney failure?

Yes No Are you on dialysis treatment?

Patient Initials: _____ *I have been given a copy of a gadolinium medication guide, for my review.*

IMPORTANT!!! - For your safety, you must remove ALL metallic and electronic objects and dress into the gown provided.

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: _____

Staff Use Only:
Reviewed By: Staff: _____ Date: _____ Staff: _____ Date: _____

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 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:_____