ADVANCED PATIENT IMAGING

Affordable Medical Imaging Services

Magnetic Resonance Imaging Patient Screening Form

WARNING: IF YOU HAVE A PACEMAKER, DEFIBRILLATOR OR ANEURYSM CLIP, ***DO NOT*** PROCEED WITH YOUR SCAN. PLEASE NOTIFY A STAFF MEMBER ***IMMEDIATELY.***

Patient Name:_____ Today's Date:_____

Age:____ Date of Birth: _____ Weight:_____ Gender: ❑ Male ❑ Female

1. Have you ever had a prior surgical procedure of any kind? ❑ Yes ❑ No

If yes, please indicate the date (approximate if unknown) and type of surgery:_____

_____

2. Have you ever experienced any problem related to a previous MRI procedure? ❑ Yes ❑ No

If yes, please explain: _____

3. Do you have any respiratory concerns that could prevent you from having a MRI procedure? ❑ Yes ❑ No

If yes, please explain:_____

4. Have you ever been a welder, grinder, or sheet metal worker? ❑ Yes ❑ No

If yes, please explain:_____

5. Have you had an eye injury involving a metallic object or fragment (metallic slivers, shavings)? ❑ Yes ❑ No

If yes, please explain:_____

6. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel)? ❑ Yes ❑ No

If yes, please explain:_____

7. Have you recently had a small bowel endoscopy/colonoscopy in the past 30 days? ❑ Yes ❑ No

If yes, how recent:_____

8. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), liver (hepatic) disease, or seizures? ❑ Yes ❑ No

If yes, please explain:_____

9. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to contrast medium or dye used for MRI, CT, or x-ray procedures? ❑ Yes ❑ No

If yes, please explain:_____

10. Have you ever had a reaction to or have been told that you should not have contrast medium injections for imaging studies? ❑ Yes ❑ No

If yes, please explain:_____

For Female Patients:

11. Are you or could you be pregnant or experiencing a late menstrual period? ❑ Yes ❑ No

12. Do you have a diaphragm/IUD in place? ❑ Yes ❑ No

13. Are you currently breastfeeding? ❑ Yes ❑ No

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Please indicate if you currently have or ever had any of the following:

Aneurysm clip(s)	❑ Yes ❑ No	Radiation seeds or implants	❑ Yes ❑ No
Cardiac pacemaker	❑ Yes ❑ No	Swan-Ganz or thermodilution catheter	❑ Yes ❑ No
Implanted cardioverter defibrillator (ICD)	❑ Yes ❑ No	Medical patch (transdermal)	
Electronic implant or device	❑ Yes ❑ No	(e.g., Nicotine, Nitroglycerine)	❑ Yes ❑ No
Magnetically activated implant or device	❑ Yes ❑ No	Any metallic fragment or foreign body	❑ Yes ❑ No
Neurostimulator (TENS unit)	❑ Yes ❑ No	Wire mesh implant	❑ Yes ❑ No
Spinal cord stimulator	❑ Yes ❑ No	Tissue expander (e.g., breast)	❑ Yes ❑ No
Bone growth/bone fusion stimulator	❑ Yes ❑ No	Surgical staples, clips, or metallic sutures	❑ Yes ❑ No
Internal electrodes or wires	❑ Yes ❑ No	Joint replacement (hip, knee, etc.)	❑ Yes ❑ No
Cochlear, otologic, or other ear implant	❑ Yes ❑ No	Bone/joint pin, screw, nail, wire, plate, etc	❑ Yes ❑ No
Insulin or other infusion pump	❑ Yes ❑ No	Intrauterine device (IUD), diaphragm	
Implanted drug infusion device	❑ Yes ❑ No	or pessary	❑ Yes ❑ No
Any type of prosthesis (e.g., eye, penile)	❑ Yes ❑ No	Braces, dentures, or partial plates	❑ Yes ❑ No
Heart valve prosthesis	❑ Yes ❑ No	Tattoo or permanent makeup	❑ Yes ❑ No
Blood clot filter	❑ Yes ❑ No	Body piercing jewelry	❑ Yes ❑ No
Eyelid spring or wire	❑ Yes ❑ No	Wig or hair implants	❑ Yes ❑ No
Artificial or prosthetic limb	❑ Yes ❑ No	Hair accessories (e.g., hairpins)	❑ Yes ❑ No
Metallic stent, filter, or coil	❑ Yes ❑ No	Other implant	❑ Yes ❑ No
Shunt (spinal or intraventricular)	❑ Yes ❑ No	Breathing problem or motion disorder	❑ Yes ❑ No
Vascular access port and/or catheter		Claustrophobia	❑ Yes ❑ No
(e.g., Broviac, Port-A-Cath, Hickman)	❑ Yes ❑ No	Hearing aid	❑ Yes ❑ No

IMPORTANT INSTRUCTIONS

Please remove all metallic objects before entering the MRI scan room, including the following:
Jewelry (e.g., earrings, rings, body piercings), hairpins, hair clips, dentures, false teeth, partial dental plates, hearing aids, eyeglasses, watch, pager, cell phone, keys, safety pins, paper clips, money clip, any magnetic strip cards (e.g., bank, credit), coins, pens, pocketknife, nail clipper, tools, and clothing with metal fasteners or containing metal thread.

NOTE: You may be advised or required to wear earplugs or other hearing protection during the MRI procedure to prevent possible problems or hazards related to acoustic noise.

I have reviewed the above information and attest that the information is accurate to the best of my knowledge. I have read and understand the entire contents of this form and had the opportunity to ask questions regarding this information and the MRI procedure.

Patient Name (please print):_____

Patient Signature:_____ **Date**:_____

OFFICE USE ONLY:
Gadolinium: _____cc's Injection time: _____ Injection site: _____ Technologist: _____

Physician signature: _____ Date: _____ Time: _____

Technologist Notes: _____
_____