Center for Diagnostic Imaging
MRI PROCEDURE SCREENING FORM FOR PATIENTS

Name _____ Date _____/_____/_____

Date of Birth _____/_____/_____ Age _____ ☐ Male ☐ Female Weight:_____

Referring Physician _____ Family Physician:_____

Reason for MRI and/or Symptoms _____

1. Have you had prior surgery / operation of any kind? ☐ No ☐ Yes
If yes, please indicate the date and type of surgery:
Date _____/_____/_____ Type of surgery_____

Date _____/_____/_____ Type of surgery_____

2. Have you had any study or examination related to todays MRI? ☐ No ☐ Yes

If yes, please list:	**Body part**	**Date**	**Facility**
MRI	_____	_____/_____/_____	_____
CT/CAT Scan	_____	_____/_____/_____	_____
X-Ray	_____	_____/_____/_____	_____
Ultrasound	_____	_____/_____/_____	_____
Nuclear Medicine	_____	_____/_____/_____	_____

3. Have you experienced any problem related to a previous MRI? ☐ No ☐ Yes
If yes, please describe: _____

4. Have you had an injury to the eye involving a metallic object or fragment (metallic slivers, shavings, foreign body, etc.)? ☐ No ☐ Yes
If yes, please describe: _____

5. Have you ever been injured by a metallic object or foreign body (BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes
If yes, please describe: _____

6. Are you currently taking or have you recently taken any medication or drug(including herbal supplements? ☐ No ☐ Yes
If yes, please list:_____

7. Are you allergic to any medication? ☐ No ☐ Yes
If yes, please list:_____

8. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium? ☐ No ☐ Yes
If yes, please describe: _____

For female patients:

Date of last menstrual period:_____/_____/_____ Post menopausal? ☐ No ☐ Yes
Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes
Are you taking oral contraceptives or receiving hormonal treatment? ☐ No ☐ Yes
Are you taking any type of fertility medication or having fertility treatments? ☐ No ☐ Yes
If yes, please describe: _____
Are you currently breastfeeding? ☐ No ☐ Yes

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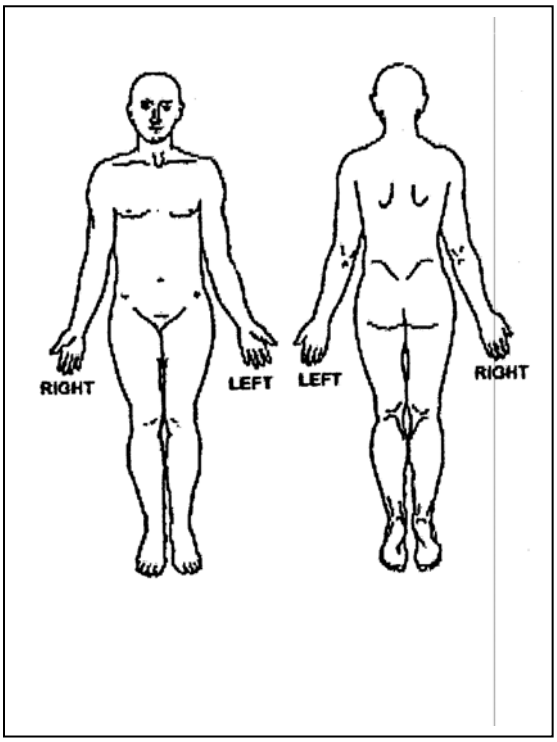
Please answer all of the following:

☐ Yes ☐ No Aneurysm clip(s)
☐ Yes ☐ No Cardiac pacemaker
☐ Yes ☐ No Implanted cardioverter defibrillator (ICD)
☐ Yes ☐ No Electronic implant or device
☐ Yes ☐ No Magnetically-activated implant or device
☐ Yes ☐ No Neurostimulation system
☐ Yes ☐ No Spinal cord stimulator
☐ Yes ☐ No Internal electrodes or wires
☐ Yes ☐ No Bone growth/bone fusion stimulator
☐ 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 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 and/or catheter
☐ Yes ☐ No Radiation seeds or implants
☐ Yes ☐ No Swan-Ganz or thermodilution catheter
☐ Yes ☐ No Medication patch (Nicotine, Nitroglycerine)
☐ Yes ☐ No Any metallic fragment or foreign body
☐ 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 Tattoo or permanent makeup
☐ Yes ☐ No Body piercing jewelry
☐ Yes ☐ No Hearing aid **(Remove before entering MR system room)**
☐ Yes ☐ No Other implant _____
☐ Yes ☐ No Breathing problem or motion disorder
☐ Yes ☐ No Claustrophobia

Please mark on the figure(s) below the location of any implants or metal inside of or on your body



Please consult the MRI Technologist or Radiologist if you have any questions or concerns BEFORE you enter the MR System room

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

Signature of Person Completing Form: _____ Date _____/_____/_____

Form Completed By: ☐ Patient ☐ Relative ☐ Nurse _____ _____
Print Name Relationship to patient

Form Information Reviewed By: _____ _____
Print name Signature Signature

☐ MRI Technologist ☐ Radiologist ☐ Other _____

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Please remove any of the following:

1. Hair pin/clips
2. Jewelry
3. Watch
4. Hearing aid
5. Cell Phone/pager
6. Earrings
7. Wallet/credit cards

(Please use restroom in needed)

A locker will be provided for all your belongings while your scan is being performed.

What influenced you to choose our facility for your Radiology needs?

Doctor referral ☐ Advertising ☐ Friend or Family ☐ Other ☐ _____

I have read and understand the above:

Patient Signature:_____ Date:_____