# MRI Patient Screening Form

This MRI patient Screening Form has to be completed on each patient prior to the initiation of the MRI exam and should be included in the complete medical record.

DATE:_____ PATIENT NUMBER_____

NAME_____ AGE_____ HEIGHT_____ WEIGHT_____

DOB _____ MALE___ FEMALE_____ BODY PART TO BE EXAMINED_____

REFERRING PHYSICIAN _____

REASON FOR MRI/SYMPTOMS_____

PRIOR SURGERIES OF ANY KIND _____

LIST ANY KNOWN DRUG ALLERGIES:_____

***Have you experience/had any issues with any of the following:***

YES_____NO_____ Claustrophobia
YES_____NO_____ Injury to the eye involving metal or metal shavings
YES_____NO_____Gunshot wounds/Shrapnel/BB
YES_____NO_____Cardiac Pacemakers
YES_____NO_____Heart Surgery/Heart Valves
YES_____NO_____Brain Aneurysm Clips/Brain Surgery
YES_____NO_____Eye Surgery/Implants/Spring Wires
YES_____NO_____ Orthopedic Pins/Screws/Joints/Prosthesis
YES_____NO_____ Neurostimulator/Biostimulator
YES_____NO_____ Spinal Cord Stimulator
YES_____NO_____ Any Type of prosthesis (Eye, Penile, Etc)
YES_____NO_____ Metallic Stent, Filter, or Coil
YES_____NO_____ Shunt (Spinal or Intraventricular)
YES_____NO_____ Medication Patch
YES_____NO_____ Any Metallic Fragment or Foreign Body
YES_____NO_____ Joint Replacement (Hip, Knee, Etc.)
YES_____NO_____ Bone/Joint Pin, Screw, Nail, Wire Plate Etc.
YES_____NO_____ Other Implants
YES_____NO_____ History of Cancer or Tumors
YES_____NO_____ Radiation/Chemo
YES_____NO_____ Ear Surgery/Cochlear Implants/Hearing Aids, Stapes Prosthesis
YES_____NO_____ Vascular Access Ports/Catheter
YES_____NO_____ Metal Mesh Implants/Wire Sutures/Wire Staples or Clips/Internal Electrodes
YES_____NO_____ Electrical/Mechanical Implants/Type
YES_____NO_____ Implanted Drug Infusion Pump/Insulin Pumps
YES_____NO_____ Tattoo's/Permanent Make-up/Body Piercings
YES_____NO_____ Do you have pins in your hair/Clothes/Hair Extensions/Hair Pieces/Wigs

**Blood Thinners**

YES____ NO____ Are you currently taking any type of blood thinner?

**MRI CONTRAST HISTORY**

| | | |
|---|---|---|
| Have you ever had MRI contrast? | _____YES | _____NO |
| If yes did you have any kind of reaction? | _____YES | _____NO |
| Do you have any history of renal disease? | _____YES | _____NO |
| Do you have any history of hypertension? | _____YES | _____NO |
| Do you have any history of diabetes? | _____YES | _____NO |
| Have you ever had severe hepatic disease or liver transplant? | _____YES | _____NO |

**IMPORTANT INSTRUCTIONS**

**Before entering the MR environment or MR system room, you must remove ALL metallic objects including but not limited to:**
**Hearing aids, keys, beeper, cell phones, eyeglasses, hair pins, barrettes, paperclips, money clips, credit cards, pens, pocket knives, nail clippers, tools, etc.**

***Please consult the MRI Technologist if you have any questions or concerns BEFORE you enter the MRI room.***

**I attest that the above information is correct to the best of my knowledge. I have informed the technologist that I am NOT pregnant at this time and I give consent to have a contrast agent administered for proper diagnosis of my procedure. I acknowledge that I am aware of the possible side effects of contrast and I have had the opportunity to ask questions related to this form, questions regarding the MRI procedure, and I understand the information presented to me.**

**Printed Patient Name:_____**

**Patient Signature:_____**

**MR Tech Signature:_____**

**Date:_____**

***For Internal Office Use Only:***

*Type of Contrast _____Lot Number_____ Exp Date _____*

*Time of Injection _____ Amount _____*