

# MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient Number \_\_\_\_\_

Name \_\_\_\_\_

Last Name

First Name

Middle Initial

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month Day Year

Age \_\_\_\_\_

Weight \_\_\_\_\_

Briefly explain the reason you are having an MRI today: \_\_\_\_\_  
\_\_\_\_\_

- |  |     |    |
|--|-----|----|
| 1. Have you had prior surgery on the body part being examined today?   | Yes | No |
| 2. Have you had a prior diagnostic exam (MRI, CT, Ultrasound, X-ray, etc.) on the body part being examined today?<br>If yes, please describe the type and date of the exam _____ | Yes | No |
| 3. Did you bring films from a prior exam with you today?   | Yes | No |
| 4. Have you experienced any problem related to a previous MRI exam or MR Procedure? If Yes, please describe _____  | Yes | No |
| 5. Have you had an injury to the eye involving a metal object or fragment (e.g., metallic slivers, shavings, foreign body, etc.)?<br>If Yes, please describe _____               | Yes | No |
| 6. Have you ever been injured by a metal object or foreign body (e.g. BB, bullet, shrapnel, etc.)? If Yes, please describe _____   | Yes | No |
| 7. Are you currently taking or have you recently taken any medication or drug? If yes, please list _____<br>_____  | Yes | No |
| 8. Are you allergic to any medication?<br>If yes, please list _____  | Yes | No |
| 9. Do you have a history or asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye use for an MRI, CT, or X-Ray Exam?                           | Yes | No |
| 10. Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease  | Yes | No |

- |                                      |     |
|--------------------------------------|-----|
| 12. Are you currently breastfeeding? | Yes |
|--------------------------------------|-----|

TECH NOTES:

Please Fill Out the Back Side of This Form



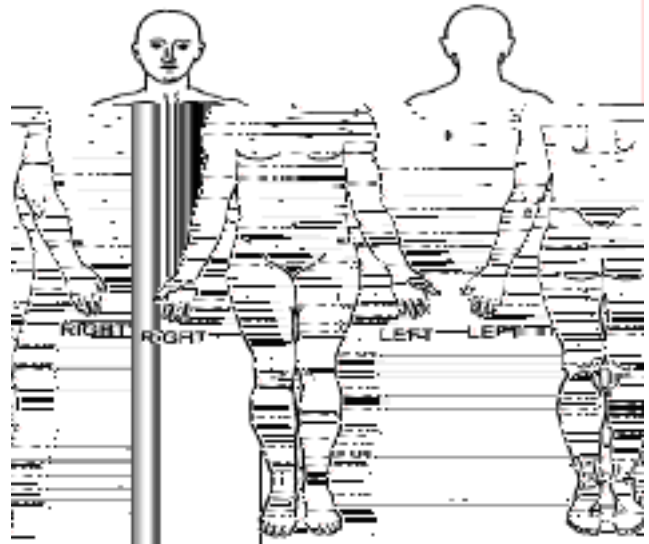


**WARNING:** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist BEFORE entering the MR system room. **The MR system magnet is ALWAYS on.**

**Please indicate if you have any of the following:**

- |  |                             |  |
|--|-----------------------------|--|
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Aneurysm clip(s)                               |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Cardiac pacemaker                              |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Implanted cardioverter defibrillator (ICD)     |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Electronic implant or device                   |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Magnetically-activated implant or device       |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Neurostimulation system                        |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Spinal cord stimulator                         |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Internal electrodes or wires                   |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Bone growth/bone fusion stimulator             |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Cochlear, otologic, or other ear implant       |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Insulin or other infusion pump                 |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Implanted drug infusion device                 |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Any type of prosthesis (eye, penile, etc.)     |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Heart valve prosthesis                         |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Eyelid spring or wire                          |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Artificial or prosthetic limb                  |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Metallic stent, filter, or coil                |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Shunt (spinal or intraventricular)             |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Vascular access port and/or catheter           |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Radiation seeds or implants                    |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Swan-Ganz or thermodilution catheter           |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Medication patch (Nicotine, Nitroglycerine)    |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Any metallic fragment or foreign body          |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Wire mesh implant                              |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Tissue expander (e.g., breast)                 |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Surgical staples, clips, or metallic sutures   |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Joint replacement (hip, knee, etc.)            |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Bone/joint pin, screw, nail, wire, plate, etc. |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | IUD, diaphragm, or pessary                     |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Dentures or partial plates                     |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Tattoo or permanent makeup                     |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Body piercing jewelry                          |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Hearing aid                                    |
| <i>(Remove before entering MR system room)</i> |                             |  |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Other implant _____                            |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Breathing problem or motion disorder           |
| <input type="checkbox"/> Yes                   | <input type="checkbox"/> No | Claustrophobia                                 |

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



**IMPORTANT INSTRUCTIONS**

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

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

I attest that the above information is correct to the best of my knowledge. I read and understand the contents of this form and 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: \_\_\_\_\_  
Signature

Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Form Completed By: ☐ Patient ☐ Relative ☐ Nurse \_\_\_\_\_  
Print name Relationship to patient

Form Information Reviewed By: \_\_\_\_\_  
Print name Signature

☐ MRI Technologist ☐ Nurse ☐ Radiologist ☐ Other \_\_\_\_\_