

Name: _____

Date of Birth: _____ Last 4 numbers of SS#: _____ Height: _____ Weight: _____

MAGNETIC RESONANCE (MRI) PROCEDURE SCREENING FORM/GENERAL QUESTIONNAIRE



WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. **DO NOT ENTER** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. **The MR MAGNET IS ALWAYS ON.** The noise level of the MRI machine is considerable. Normally the earplugs provided are sufficient. If you would also like to use headphones (not allowed on all procedures), please inform the technologist.

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, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, and clothing with metallic threads. **PLEASE CONSULT THE MRI TECHNOLOGIST OR RADIOLOGIST IF YOU HAVE ANY QUESTIONS OR CONCERNS BEFORE YOU ENTER THE MR SYSTEM ROOM.**

1. Reason for MRI and/or symptoms: _____
 Headaches Pain Numbness Other: _____
 How long have you had this problem? _____ Symptoms worse: Left Right
2. Prior Studies: Have you had any previous imaging studies of the part being examined today? Yes No
 Where: _____ When: _____
Type of Exam: X-Ray CT MRI Ultrasound Nuclear Medicine PET
3. Have you had any major surgeries? Yes No Where: _____ When: _____
 Heart Back/neck Gall Bladder Uterus Appendix Other _____
4. Medical History (Check all that apply): First date of last menstrual period: _____
 Diabetes High Blood Pressure Smoking Kidney Disease Asthma/COPD
 Cancer - personal history (specify type): _____
 Cancer - family history (specify type): _____
5. Have you ever had an allergic reaction to IV contrast material used in an imaging procedure (Iodine or Gadolinium)?
 No Yes : Please explain _____
 Allergic to latex? Yes No
6. Are you pregnant, or is there a chance that you may be pregnant? Yes No N/A
7. Are you Claustrophobic? Yes No
8. Have you had an injury to the eye involving a metallic object or fragment (e.g. metallic slivers, shavings, foreign body, sheet metal work, welding etc.? If yes, please explain _____
9. Have you ever been injured by a metallic object or foreign body (e.g. bullet, shrapnel, etc.)? Please explain: _____
10. Are you currently taking any muscle relaxer or sedative? If yes, please explain: _____

Please indicate if you have any of the following:

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aneurysm Clips | <input type="checkbox"/> Yes <input type="checkbox"/> No Metallic Stent, Filter, or Coil |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac Pacemaker | <input type="checkbox"/> Yes <input type="checkbox"/> No Shunt (spinal or intraventricular) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted Cardioverter Defibrillator/Aicd | <input type="checkbox"/> Yes <input type="checkbox"/> No Vascular access port and/or catheter |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Electronic Implant or device | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation seeds or implants |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Magnetically-activated implant/device | <input type="checkbox"/> Yes <input type="checkbox"/> No Swan-Ganz or thermodilution catheter |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Neurostimulation system | <input type="checkbox"/> Yes <input type="checkbox"/> No Medication patch (Nicotine, Nitroglycerine) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Spinal Cord Stimulator | <input type="checkbox"/> Yes <input type="checkbox"/> No Wire mesh Implant |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Internal Electrodes or wires | <input type="checkbox"/> Yes <input type="checkbox"/> No Tissue expander (e.g., breast) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bone growth/bone fusion stimulator | <input type="checkbox"/> Yes <input type="checkbox"/> No Surgical staples, clips, metallic sutures |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cochlear, otologic, or other ear implant | <input type="checkbox"/> Yes <input type="checkbox"/> No Joint replacement (hip, knee, etc.) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Insulin or other infusion pump | <input type="checkbox"/> Yes <input type="checkbox"/> No Bone/joint pin, screw, nail, wire, plate, etc. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted drug infusion device | <input type="checkbox"/> Yes <input type="checkbox"/> No Dentures or partial plates |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Any type of prosthesis (eye, penile, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No Tattoo or permanent makeup |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Valve prosthesis | <input type="checkbox"/> Yes <input type="checkbox"/> No Body piercing jewelry |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Eyelid Spring or Wire | <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing aid (Remove before entering room) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial or Prosthetic Limb | <input type="checkbox"/> Yes <input type="checkbox"/> No Breathing problem or motion disorder |

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 information on this form and the MR procedure that I am about to undergo.

Signature of person completing the form: _____ Date ____/____/____

Signature

Relationship to patient

Reviewed by (Technologist Name): _____ Date ____/____/____

Print Name

Signature

Reviewed by: _____ Date ____/____/____

Print Name

Signature



MAGNETIC RESONANCE (MRI) CONTRAST FORM

Patient Name: _____ / _____ / _____
First Name Last Name Middle Initial Date of Birth

Last 4 numbers of SS#: _____

Patient Fasting? Yes No

Contrast type injected: _____ Volume _____ ml. Lot#: _____ Exp. Date ____ / ____ / ____

IV access: Time: _____ Location: _____ Catheter size/type: _____ Number of Attempts: _____

IV Started By: _____ Injected By: _____

Allergy problems post contrast? Yes No

If yes, complete Contrast Incident Form. Date Lab Drawn ____ / ____ / ____

Creatinine within normal limits Yes No NA

If no, Creatinine level _____ GFR: _____

Comments: _____

Reviewed by (Technologist Name): _____ Date ____ / ____ / ____
Print Name Signature

Reviewed by: _____ Date ____ / ____ / ____
Print Name Signature