BAPTIST M&S IMAGING

Name:_____

Date of Birth:_____Acct/SS#:_____ Height:_____ Weight:_____

MAGNETIC RESONANCE (MRI) PROCEDURE SCREENING FORM/GENERAL QUESTIONAIRE

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.**

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 When:_____ Where:_____
   ☐ 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 (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: _____

☐ Yes ☐ No Aneurysm Clips
☐ Yes ☐ No Cardiac Pacemaker
☐ Yes ☐ No Implanted Cardioverter Defibrillator/Aicd
☐ Yes ☐ No Electronic Implant or device
☐ Yes ☐ No Magnetically-activated implant/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 Wire mesh Implant
☐ Yes ☐ No Tissue expander (e.g., breast)
☐ Yes ☐ No Surgical staples, clips, metallic sutures
☐ Yes ☐ No Joint replacement (hip, knee, etc.)
☐ Yes ☐ No Bone/joint pin, screw, nail, wire, plate, etc.
☐ Yes ☐ No Dentures or partial plates
☐ Yes ☐ No Tattoo or permanent makeup
☐ Yes ☐ No Body piercing jewelry
☐ Yes ☐ No Hearing aid (Remove before entering room)
☐ Yes ☐ 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

BAPTIST M&S IMAGING

MAGNETIC RESONANCE (MRI) CONTRAST FORM

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

Account/SSN#:_____

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

Reset Form