SMH Imaging Center℠

MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Date: _____/ _____/ _____ Medical Record Number: _____ Acct #: _____

Name: _____ Weight: _____

Date of Birth: _____/ _____/ _____ Gender: ◯ M ◯ F Body Part to be Examined: _____

Reason for MRI and/or Symptoms: _____

_____

1. Have you had prior surgery or an operation (e.g. arthroscopy, endoscopy, etc.) of any kind? ◯ Yes ◯ No
   If yes, please indicate the date and type of surgery:
   Date: _____/ _____/ _____ Type of surgery: _____
   Date: _____/ _____/ _____ Type of surgery: _____
2. Have you had a prior diagnostic imaging study or examination (MRI, CT, Ultrasound, X-ray, etc.)? ◯ Yes ◯ No

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

3. Are you Claustrophobic? ◯ Yes ◯ No
4. Have you experienced any problem related to a previous MRI examination or MR procedure? ◯ Yes ◯ No
   If yes, please describe: _____
5. Have you had an injury to the eye involving a metallic object or fragment ◯ Yes ◯ No
   (e.g. metallic slivers, shavings, froeign body, etc.)?
   If yes, please describe: _____
6. Have you ever been injured by a metallic object or foreign body (e.g. BB, bullet, shrapnel, etc.)? ◯ Yes ◯ No
   If yes, please describe: _____

Female patients only:

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

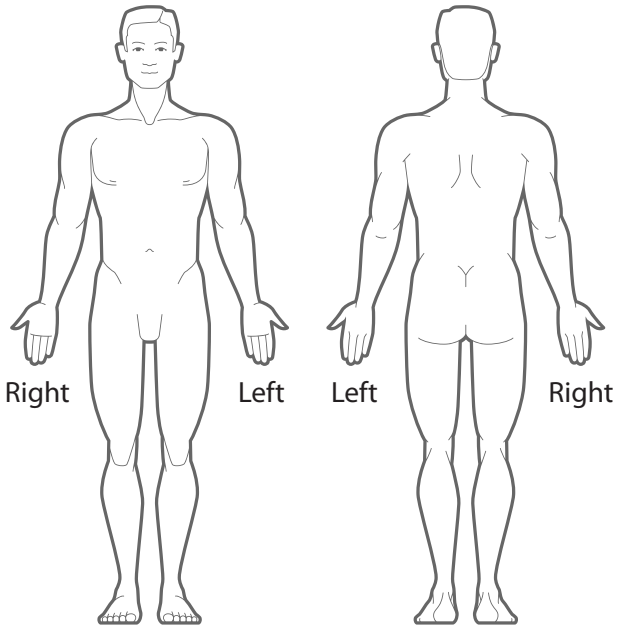
WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e. MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any questions or concern regarding an implant, device or object.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

Please turn over

Please indicate if you have any 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 simulator
- ◯ 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 pessary
- ◯ 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 systems room)
- ◯ Yes ◯ No Other implant _____

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



Please indicate location of complaint.

	Leg		Arm	
Pain	◯ R	◯ L	◯ R	◯ L
Weakness	◯ R	◯ L	◯ R	◯ L
Numbness	◯ R	◯ L	◯ R	◯ L

Please shade in area of pain, weakness, or numbness.

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

NOTE: Your specific procedure may not allow hearing protection during the MR procedure in order for you to hear breathing instructions from the Technologist

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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 Patient: _____ Date: ____/ ____/ _____

Form Completed by: _____ ◯ Patient ◯ Relative ◯ Nurse

Print name

Signature of Technologist Reviewing Form: _____