Southern Diagnostic Imaging Center

Magnetic Resonance Imaging Patient Screening Form

NAME _____ PRESENT WEIGHT _____

What are your symptoms/problems? _____

MEDICAL HISTORY

DO YOU HAVE ANY OF THE FOLLOWING?

___ Kidney Disease ___ Asthma ___ Other Allergic Respiratory Disease ___ Seizures ___ Cancer

___ Blood Disorders ___ Diabetes

DO YOU HAVE ANY DRUG ALLERGIES? Y or N
IF YES, PLEASE LIST _____

ARE YOU ALLERGIC TO ANY TYPE OF DYE USED FOR MRI, CT, OR ANY OTHER X-RAY PROCEDURE? Y or N
IF YES, PLEASE DESCRIBE _____

PLEASE LIST ALL SURGERIES WITH THE DATES. _____

_____

_____

HAVE YOU EVER BEEN INJURED BY A METAL OBJECT/FOREIGN BODY (e.g. bullet, BB, shrapnel)? Y or N
IF YES, PLEASE DESCRIBE. _____

HAVE YOU EVER HAD AN INJURY FROM A METAL OBJECT IN YOUR EYE? Y or N
(e.g. metal slivers, metal shavings, or other metal object)
IF YES, PLEASE DESCRIBE: _____
WAS THE METALLIC OBJECT REMOVED BY A DOCTOR? Y or N

FEMALE PATIENTS ONLY:

ARE YOU PREGNANT OR DO YOU SUSPECT YOU ARE PREGNANT? Y or N
ARE YOU BREAST FEEDING? Y or N
ARE YOU POST MENOPAUSAL? Y or N

DATE OF LAST MENSTRUAL CYCLE IF NOT POST MENOPAUSE._____

ATTENTION MRI PATIENTS AND/OR FAMILY MEMBERS:

The MR room contains a very strong magnet. Before you are allowed to enter, we must know if you have any of the following in your body. **If you must answer "yes" to any item below you are not a candidate for MRI, nor will you be able to enter the MRI room.**

Pacemaker, Wires, or Defibrillator Y or N
Brain/Aneurysm Clip(s) Y or N
Electrical Devices such as Tens Unit or Infusion Pump not Removable Y or N
Cochlear Implant or Nonremovable Hearing Aid Y or N
Magnetic Implant Anywhere Y or N

Continued on other Side

THE FOLLOWING ITEMS MAY INTERFERE WITH THE MRI EXAMINATION. YOU MUST PROVIDE A YES OR NO FOR EVERY ITEM. DO YOU HAVE ANY OF THE FOLLOWING:

Y N 1. ANY TYPE OF INTERNAL ELECTRODE(S) OR WIRE(S)
Y N 2. COIL, FILTER, WIRE, OR STENT IN A BLOOD VESSEL
Y N 3. ARTIFICIAL LIMB, JOINT, OR EYE
Y N 4. HEARING AID
Y N 5. REMOVABLE DRUG INFUSION PUMP (e.g. insulin, pain medicine, chemotherapy)
Y N 6. SPINAL FUSION PROCEDURE WITH METAL HARDWARE
Y N 7. ARTIFICIAL HEART VALVE
Y N 8. ANY TYPE OF EAR IMPLANT
Y N 9. PENILE IMPLANT OR PROSTHESIS
Y N 10. EYELID SPRING
Y N 11. ANY TYPE OF IMPLANT HELD IN PLACE BY A MAGNET
Y N 12. ANY TYPE OF SURGICAL CLIP OR STAPLE
Y N 13. ANY I.V. ACCESS PORT (e.g., Broviac, Port-a-Cath, Hickman, Picc Line)
Y N 14. MEDICATION PATCH (e.g. Nitroglycerine, nicotine)
Y N 15. ANY TYPE OF SHUNT
Y N 16. ANY TYPE OF TISSUE EXPANDER (e.g. breast)
Y N 17. REMOVABLE DENTURES, FALSE TEETH, OR PARTIAL PLATE
Y N 18. DIAPHRAGM, IUD, PESSARY
Y N 19. SURGICAL MESH
Y N 20. BODY PIERCING (LOCATION: _____)
Y N 21. WIG, HAIR IMPLANTS
Y N 22. TATTOOS OR TATTOOED EYELINER
Y N 23. RADIATION SEEDS (e.g. cancer treatment)
Y N 24. ANY IMPLANTED ORTHOPEDIC ITEMS (e.g. pins, rods, screws, nails, plates, wires)
Y N 25. ANY OTHER TYPE OF IMPLANTED ITEM (LOCATION: _____)

PATIENT INSTRUCTIONS:

1. Remove all jewelry, with the exception of wedding rings or bands.
2. Remove all hair pins, bobby pins, barrettes, clips, wigs, etc.
3. Remove all dentures, false teeth, partial plates if they have any metal.
4. Remove all hearing aids.
5. Remove eyeglasses.
6. Remove your watch, pager or cell phone (must be turned off or on silent), credit and bank cards, and all other cards with a magnetic strip.
7. Remove body piercing objects.
8. You will be provided with a gown so that all clothing with metal can be removed.
9. You are urged to use earplugs that will be provided for use during your exam since some patients may find the noise levels unacceptable and the noise levels may affect your hearing.

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 I have asked questions, as needed, regarding the information on this form.

Patient Signature: _____ Date: _____

OFFICE USE ONLY:

MRI Technologist Signature: _____ Date: _____

Contrast Injection Documentation

Type of contrast administered: Prohance
Amount given: _____cc's

Injection site: _____
Any Problems? Y N
If yes, please describe._____
In case of a reaction please document Lot No. and notify Bracco.
LOT NO._____