MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

*PLEASE USE BLACK OR BLUE INK*

<table>
<thead>
<tr>
<th>Date</th>
<th>Time (scheduled)</th>
<th>Study Number(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Last name First name</td>
<td>Age Height Weight</td>
</tr>
</tbody>
</table>

Date of Birth __________________   Male ☐ Female ☐

month day year

Body Part to be examined __________________   Referring Physician __________________

Tech Notes: __________________

Contrast __________________

Have you ever had any surgery or procedure on the part of the body we’re scanning today? ☐ No ☐ Yes

If yes, please indicate the date and type of surgery: __________________

Have you ever had any other surgery or procedure that left any implanted metallic or electronic devices? ☐ No ☐ Yes

If yes, please indicate the date and type of surgery: __________________

Have you ever had an MRI before? If yes, body part? ☐ No ☐ Yes

If yes, location and date? (month/year) __________________

Have you experienced any problem related to a previous MRI examination or MR procedure? ☐ No ☐ Yes

If yes, please describe: __________________

Have you had any other diagnostic imaging studies on the part of the body we’re scanning today? ☐ No ☐ Yes

<table>
<thead>
<tr>
<th>X-ray</th>
<th>When</th>
<th>Where</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAT Scan (CT)</td>
<td>When</td>
<td>Where</td>
</tr>
<tr>
<td>Bone Scan</td>
<td>When</td>
<td>Where</td>
</tr>
</tbody>
</table>

Have you had an injury to the eye involving metallic objects/fragments (metallic slivers, shavings, etc.)? ☐ No ☐ Yes

If yes, please describe: __________________

Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? ☐ No ☐ Yes

If yes, please describe: __________________

Are you currently taking or have you recently taken any medication or drug? ☐ No ☐ Yes

If yes, please list: __________________

Are you allergic to any medication? ☐ No ☐ Yes

If yes, please list: __________________

Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ☐ No ☐ Yes

**Do you have any renal (kidney) disease, reduced renal function or renal failure?** ☐ No ☐ Yes

Do you have any known personal history of Cancer? ☐ No ☐ Yes

If yes, please list: __________________

Have you ever undergone chemo- or radiation therapy? ☐ No ☐ Yes

If yes, when & what body part (radiation): __________________

Do you have anemia or any disease(s) that affects your blood, a history of renal (kidney) disease or seizures? ☐ No ☐ Yes

If yes, please describe: __________________

Are you currently a smoker or have you smoked regularly in the past? ☐ No ☐ Yes

If yes, how many packs per day ________________ and for how long ________________

**For female patients:**

Date of last menstrual period: _____/_____/_____ Postmenopausal? ☐ No ☐ Yes

Are you pregnant or experiencing a late menstrual period? ☐ No ☐ Yes

Are you currently breastfeeding? ☐ No ☐ Yes
**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:

- Aneurysm clip(s)  □ No  □ Yes
- Cardiac pacemaker  □ No  □ Yes
- Implanted cardioverter defibrillator (ICD)  □ No  □ Yes
- Any other electronic implant or device  □ No  □ Yes
- Magnetically-activated implant or device  □ No  □ Yes
- Neurostimulation system  □ No  □ Yes
- Spinal cord stimulator  □ No  □ Yes
- Internal electrodes or wires  □ No  □ Yes
- Bone growth/bone fusion stimulator  □ No  □ Yes
- Cochlear, otologic, or other ear implant  □ No  □ Yes
- Insulin or other infusion pump  □ No  □ Yes
- Implanted drug infusion device  □ No  □ Yes
- Any type of prosthesis (eye, penile, etc.)  □ No  □ Yes
- Heart valve prosthesis  □ No  □ Yes
- Eyelid spring or wire  □ No  □ Yes
- Artificial or prosthetic limb  □ No  □ Yes
- Metallic stent, filter, or coil  □ No  □ Yes
- Shunt (spinal or intraventricular)  □ No  □ Yes
- Vascular access port and/or catheter  □ No  □ Yes
- Radiation seeds or implants  □ No  □ Yes
- Swan-Ganz or thermodilution catheter  □ No  □ Yes
- Medication patch (Nicotine, Nitroglycerine)  □ No  □ Yes
- Any metallic fragment or foreign body  □ No  □ Yes
- Wire mesh implant  □ No  □ Yes
- Tissue expander (e.g., breast)  □ No  □ Yes
- Surgical staples, clips, or metallic sutures  □ No  □ Yes
- Where: _________________________

- Joint replacement (hip, knee, etc.)  □ No  □ Yes
- Bone/joint pin, screw, nail, wire, plate, etc.  □ No  □ Yes
- IUD, diaphragm, or pessary  □ No  □ Yes
- Dentures or partial plates  □ No  □ Yes
- Tattoo or permanent makeup  □ No  □ Yes
- Body piercing jewelry  □ No  □ Yes
- Hearing aid *(Remove before entering MRI room)*  □ No  □ Yes
- Other implant _________________________  □ No  □ Yes
- Breathing problem or motion disorder  □ No  □ Yes
- Claustrophobia  □ No  □ Yes

Please mark on the figure(s) below the location of any area of pain related to the exam you are having today.

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**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.

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

**NOTE:** Notify MR staff immediately if “YES” to any of the above.

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: __________________________________________ Date ____ / ____ / ____

Form Completed By: □ Patient □ Relative □ Nurse __________________________________________ Print name Relationship to patient

Form Information Reviewed By: __________________________________________ Print name

Signature □ MRI Technologist  □ MRI Tech Assistant  □ Radiologist  □ Other