MRI Screening Form

Patient Name _____ DOB _____

Weight _____ Height _____ Gender at birth: ❑Male ❑Female

	Answer	Comments
1. Do you have or have you ever had a pacemaker, pacing wires, implanted cardioverter defibrillator (ICD), Life Vest or artificial heart valve?	Yes / No	
If **YES**, Add comment, make and model #, etc. if possible.		
2. Have you had any surgery anywhere in your body?	Yes / No	
If **YES**, list all surgeries.		
3. Have you had any metal or shrapnel in your body or eyes even if it has been previously removed (plates, screws, rods, metal shavings, bullets)?	Yes / No	
If **YES**, list where in your body.		
4. Do you have any aneurysm clips, stents, coils, filters, devices, removable prosthetics, or implants (bone growth or spinal cord stimulator, deep brain stimulator, breast implants)?	Yes / No	
If **YES**, what type of item? (Add comment, make and model number, etc. if possible)		
5. Do you have any gastrointestinal (GI) clips? (Olympus, LINX Device, etc.)	Yes / No	
6. Do you have an IUD, diaphragm, pessary, or breast tissue expander?	Yes / No	
7. Do you have any pumps, tubes, catheters, probes, arterial lines, intracranial pressure lines or shunts? If **YES**, please list.	Yes / No	
8. Do you have a shunt? (spinal or intraventricular)	Yes / No	
If **YES**, is the Shunt programmable?	Yes / No	
9. Do you have a Continuous Glucose Monitor, or any jewelry to include body piercings, removable dental devices, temporary spacers, hearing aids or magnetic cosmetics including eyelashes or nail polish? (These will need to be removed.)	Yes / No	
10. Do you have any nicotine or medication patches or any silver containing dressing? (These will need to be removed.)	Yes / No	
11. Do you have any tattoos or permanent makeup?	Yes / No	
12. Are you pregnant or suspect you are pregnant?	Yes / No	
13. Are you currently breast feeding?	Yes / No	
14. Are you claustrophobic?	Yes / No	
15. Do you have any of the following conditions? (Circle all that apply)	None, CHF, High Blood Pressure, Diabetes, Kidney Disease	
If you circled **Kidney Disease**, which types apply?	Kidney Cancer, Kidney Surgery, Kidney Transplant, One Kidney, Other	
16. Are you on Dialysis?	Yes / No	
17. Are you allergic to any form of MRI contrast media (Gadolinium) or dye?	Yes / No	
18. Do you have a personal history of cancer? Yes / No If yes, type: _____		
Who answered the questions on this form?	Patient, Family Member, Power of Attorney, Other	
If the form was completed by a Family Member, Power of Attorney, or Other, please provide their name.		
Who reviewed form with patient entering responses?	Nurse, MR Tech, Interpreter, Other	

❑ **Your doctor has ordered an exam that requires a dye, that shows up on MRI, to be injected into a vein. Any intravenous procedure has risks involved, and successful IV insertion is not guaranteed. You have a right to refuse this injection, but this may provide less diagnostic information. Common risks of an IV include infiltration, infection, or inflammation of the vein or surrounding tissue. Some patients have a mild reaction to the dye, and may develop nausea, sneezing, flushing of the skin, and hives. Rarely (1 case in 1,000) a more serious reaction to the dye can occur. The physicians and staff of The Imaging Center are trained to treat these reactions.**

_____ _____

Patient / Representative Signature Date

_____ _____

Staff Signature Date