

MRI PATIENT SCREENING

Patient name _____ MR# _____ SS# _____ / _____ / _____

Procedure _____ Doctor _____

Date of Birth ____/____/____ Age: _____ Weight: _____ Sex: Male Female

CIRCLE CORRECT ANSWER—IF YOU ANSWER YES TO ANY OF THE QUESTIONS 1-7 STOP & TELL SOMEONE!!

Do you have a pacemaker ? If yes, STOP & TELL SOMEONE!	Yes	No
Have you ever had metal fragments in your eyes?	Yes	No
If yes, have they been removed? When? _____	Yes	No
Have you ever had brain surgery?	Yes	No
If yes, do you have brain clips?	Yes	No
Do you have removable dental work?	Yes	No
Are you claustrophobic?	Yes	No
Do you yourself have a history of cancer?	Yes	No
If yes, where? _____ Do you still have cancer?	Yes	No
Any previous injury?	Yes	No
If so, what? _____ When? _____		
Any previous surgery?	Yes	No
If so, when, where and what type of surgery? _____		
Have you had a previous MRI of the area we are scanning today?	Yes	No
If yes, when? _____ Where? _____		

Women only: Are you pregnant at this time? Yes No Do you have an IUD? Yes No

THE FOLLOWING ITEMS CAN INTERFERE WITH MRI IMAGING AND SOME MAY JEOPARDIZE YOUR SAFETY, PLEASE INDICATE WITH A CHECK MARK IF YOU HAVE ANY OF THESE ITEMS IN YOUR BODY.

<input type="checkbox"/> Aortic clips	<input type="checkbox"/> Joint replacements
<input type="checkbox"/> Carotid clips	<input type="checkbox"/> Bone or joint pins
<input type="checkbox"/> Heart valve replacement	<input type="checkbox"/> Prosthesis
<input type="checkbox"/> Insulin pump or port	<input type="checkbox"/> Metal mesh
<input type="checkbox"/> Infusion pump(porta cath)	<input type="checkbox"/> Wire sutures
<input type="checkbox"/> Hearing aids	<input type="checkbox"/> Shrapnel/BB's/Buckshot
<input type="checkbox"/> Cochlear implant in ear	<input type="checkbox"/> Any other metal or foreign body,
<input type="checkbox"/> Shunt in brain	describe _____
<input type="checkbox"/> Penile implant	

How long have you had pain? _____ Where is it located? _____

Which side hurts worse? Right Left Both Weakness? Right Left Dizziness? Yes No

Numbness in your arms, hands, legs and feet? (please circle) Right Left Both

THIS PROCEDURE WILL BE EXPLAINED TO YOU AND ALL YOUR QUESTIONS ADDRESSED PRIOR TO THE MRI SCAN.

I DO NOT HAVE A PACEMAKER, NOR HAVE I HAD SURGERY REQUIRING ANEURYSM CLIPS. I DO NOT HAVE COCLEAR IMPLANTS IN THE EAR, NOR DO I HAVE METALLIC FOREIGN BODIES IN THE EYE. I AM FULLY AWARE THAT IF I HAVE ANY OF THE ABOVE, AN MRI SCAN COULD BE HAZARDOUS TO MY HEALTH. THE ABOVE QUESTIONS HAVE BEEN ANSWERED TRUTHFULLY AND I AGREE TO THE MRI STUDY.

PATIENT'S SIGNATURE _____ DATE ____/____/____