**MRI PATIENT SCREENING**

Patient Name ____________________________________________________MR#________________________

Social Security Number ___________________________Date of Birth_________________ Age________ Weight_________

1. Yes No Do you have a pacemaker? If yes, STOP & NOTIFY SOMEONE!
2. Yes No Do you have pacemaker leads?
3. Yes No Have you ever had metal fragments in your eyes?
4. Yes No If "yes", have they been removed? When? _________________
5. Yes No Have you ever had brain surgery?
6. Yes No If yes, do you have aneurysm/brain clips?
7. Yes No Have you had a tattoo or cosmetic coloring (example:eyelashes,eyeliner) in the past 12 months?
8. Yes No Have you ever been diagnosed or do you presently have Nephrogeniystemic Fibrosis (NSF)?
9. Yes No Have you ever had heart surgery?
10. Yes No If yes, do you have artificial heart valves?
11. Yes No Have you ever had inner ear surgery?
12. Yes No Do you have an IVC umbrella?
13. Yes No Do you have a neurostimulator device?
14. Yes No Are you wearing a pain patch?
15. Yes No Do you have removable dental work, i.e. dentures or partials?
16. Yes No Do you have asthma?
17. Yes No Are you claustrophobic?

**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.**

| | | | |
|---|---|---|---|
| ________ | Aortic Clips | ________ | Metal Joint Replacements |
| ________ | Carotid Clips | ________ | Bone or Joint Pins, Rods, or Screws |
| ________ | Heart Valve Replacement | ________ | Prosthesis |
| ________ | Insulin Pump or Port | ________ | Metal Mesh |
| ________ | Infusion Pump (Porta Cath) | ________ | Wire Sutures |
| ________ | Hearing Aids | ________ | Shrapnel/BB's/Buckshot |
| ________ | Cochlear Implant in Ear | ________ | Any other metal or foreign body |
| ________ | Shunt in Brain | | Describe ___________________________ |

Yes No Have you had X-rays of area we are scanning today?
If Yes, when? _______________________ Where? ______________________________

Yes No Have you had a previous MRI of the area we are scanning today?
If Yes, when? ____________________ Where? ________________________________

Yes No Do you, yourself, have a history of cancer?
If yes, where? _________________________________ Do you still have cancer? ______

Yes No Are you pregnant at this time?

Yes No Do you have an IUD? If yes, what kind? ________________________________________

How long have you had pain? _______________________ Where is it located?__________________________________

Which side hurts worse? Right Left Both Weakness? Right Left

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 cochlear 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 ______________

I have reviewed and assessed the patient: ___Y ___ N Tech Initials: _________