



# MRI PROCEDURE SCREENING FORM

PATIENT NAME \_\_\_\_\_ WEIGHT \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

EXAM \_\_\_\_\_ DIAGNOSIS \_\_\_\_\_

REFERRING DR. \_\_\_\_\_ PRIMARY DR. \_\_\_\_\_

Please describe your pain, discomfort and/or symptoms relating to your MRI today.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had surgery?  YES  NO

Please list surgeries \_\_\_\_\_  
\_\_\_\_\_

Since birth to present:

Have you ever had metal in your eyes? (i.e. bullet, bb, shrapnel, metallic shavings)  YES  NO

If yes, please describe \_\_\_\_\_

Have you ever had metal in your body?  YES  NO

If yes, please describe \_\_\_\_\_

Date of last menstrual period \_\_\_\_\_

Are you breast feeding?  YES  NO

Are you pregnant?  YES  NO

Have you ever had a reaction to contrast or MR/CT/IVP procedure?  YES  NO

Please check any of the following that you have had:

Seizures  Kidney Disease  Asthma  Drug Allergies

Anemia  Other diseases that affect your blood \_\_\_\_\_

Cancer If yes, what type? \_\_\_\_\_

Please list any allergies: \_\_\_\_\_

Please list any/all of the following types of procedures you have had:

<i>Exam</i>	<i>Date and facility</i>	<i>Exam performed for what type of problems</i>
Xray	_____	_____
Ultrasound	_____	_____
CT Scan	_____	_____
MRI	_____	_____
Nuclear Medicine	_____	_____

**We will provide you with a set of earplugs to quiet the high level of noise you may experience during your procedure.**

**FOR OFFICE USE ONLY BELOW THIS LINE**

Tech Comments: \_\_\_\_\_

INT Size \_\_\_\_\_ Location \_\_\_\_\_ Irrigates w/o resistance  YES  NO Tech \_\_\_\_\_

Contrast \_\_\_\_\_ Amount \_\_\_\_\_ Radiologist \_\_\_\_\_

INT DC'd:  YES  NO IV within normal limits  YES  NO Discharge Time \_\_\_\_\_

Change from initial assessment?  YES  NO

**TEACHING DATA:**

Type of procedure: \_\_\_\_\_

Procedure and pre and post preparation explained to:

Patient  Father  Mother  Guardian  Other \_\_\_\_\_ Tech Signature \_\_\_\_\_

Verbalizes understanding of procedure and post procedure instructions:  YES  NO

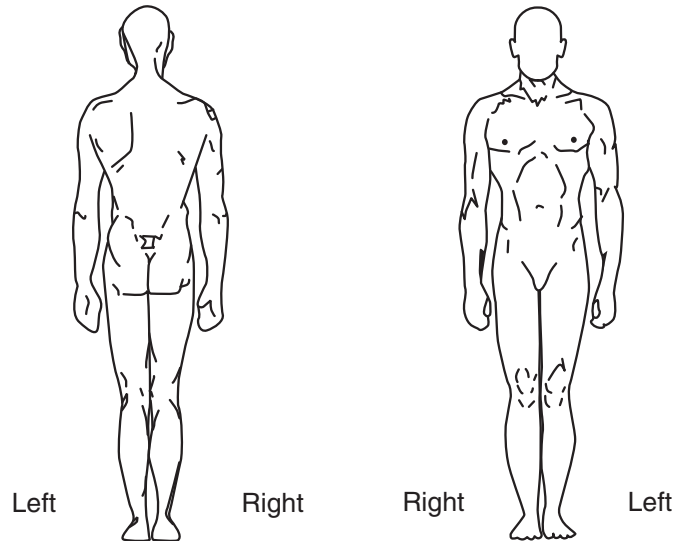
**Please Indicate If You Have Any Of The Following:**

If you mark any of the below that has an asterisk, please provide a card given to you by your physician explaining what the device is and what it is made of.

- |  |  |
|--|--|
| <input type="checkbox"/> Cardiac pacemaker               | <input type="checkbox"/> Any type of biostimulator TYPE _____  |
| <input type="checkbox"/> Aneurysm clip(s)                | <input type="checkbox"/> Halo vest or metallic cervical fixation device  |
| <input type="checkbox"/> Implanted cardiac defibrillator | <input type="checkbox"/> Any type of implant held in place by a magnet   |
| <input type="checkbox"/> Neurostimulator                 | <input type="checkbox"/> Any type of surgical clip or staple   |
| <input type="checkbox"/> Implanted insulin pump          | <input type="checkbox"/> Any type of foreign body, shrapnel, or bullet   |
| <input type="checkbox"/> Swan-Ganz catheter              | <input type="checkbox"/> Implanted drug fusion device  |
| <input type="checkbox"/> Heart valve prosthesis          | <input type="checkbox"/> Pessary   |
| <input type="checkbox"/> Hearing aid                     | <input type="checkbox"/> Any type of electronic, mechanical or magnetic implant<br>TYPE _____                                  |
| <input type="checkbox"/> Any type of ear implant         | <input type="checkbox"/> Any type of intravascular coil, filter or stent<br>(Gianturco coil, Gunther IVC filter, Palmaz stent) |
| <input type="checkbox"/> Penile prosthesis               | <input type="checkbox"/> Any type of internal electrodes, including Pacing wires,<br>Cochlear implant OTHER _____              |
| <input type="checkbox"/> Orbital/eye prosthesis          | <input type="checkbox"/> Any implanted orthopedic item (pins, rods, screws,<br>nails, clips, plates, wires...) TYPE _____      |
| <input type="checkbox"/> Intraventricular shunt          |  |
| <input type="checkbox"/> Artificial limb or joint        |  |
| <input type="checkbox"/> Dentures                        |  |
| <input type="checkbox"/> IUD                             |  |
| <input type="checkbox"/> Tattooed eyeliner               |  |

A small percentage of patients with tattooed eyeliner have experienced transient skin irritation with MRI. You must decide if this slight risk warrants undergoing your examination. You may want to discuss this matter with your referring physician.

**Please shade areas of the body where you are experiencing pain.**



I hereby attest that the information I have given is true, correct and complete to best of my knowledge. I have read documents in its entirety and understand its content. I further state that I have been given the opportunity to have addressed any concerns I may have regarding any of the questions I have answered, as well as questions or concerns I may have regarding the procedure I am scheduled to undergo and thereby hold Pinnacle Medical Center harmless hereof.

Signature \_\_\_\_\_ Date \_\_\_\_\_