Pinnacle
MEDICAL GROUP

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:

Exam	*Date and facility*	*Exam performed for what type of problems*
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

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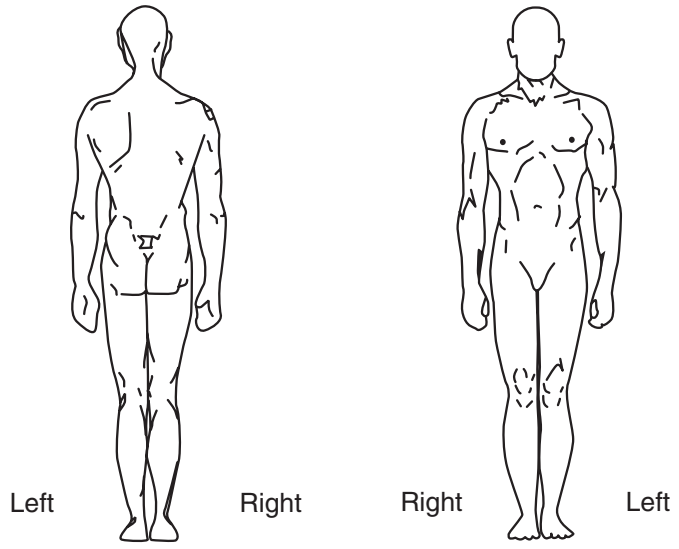
Please Indicate If You Have Any Of The Following:

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.

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

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_____