



MAGNETIC RESONANCE (MR) PROCEDURE SCREENING FORM FOR PATIENTS

Name: _____ Account/SS#: _____
Last Name First Name Middle Initial

Date of Birth: _____ Body Part to be Examined: _____

1. Have you had prior surgery or an operation (e.g., arthroscopy, cardiac catheterization, etc.) of any kind? Yes No
If yes, please indicate the date and type of surgery:
Date: ___/___/___ Where: _____ Type of surgery: _____

2. Have you experienced any problem related to a previous MRI examination or MR procedure? Yes No
If yes, please describe: _____

3. Have you had an injury to the eye involving a metallic object or fragment (e.g., metallic slivers, shavings, foreign body, sheet metal work, welding, etc.)? Yes No
If yes, please describe: _____

4. Have you ever been injured by a metallic object or foreign body (e.g., BB, bullet, shrapnel, etc.)? Yes No
If yes, please describe: _____

5. Are you currently taking or have you recently taken any muscle relaxer or sedative? Yes No
If yes, please list: _____

6. Are you allergic to any medication? Yes No
If yes, please list: _____

7. Do you have a history of asthma, respiratory disease or allergic reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? Yes No
If yes, please describe: _____

8. Do you have a history of renal (kidney) disease, renal (kidney) failure, renal (kidney) transplant, high blood pressure (hypertension), diabetes, liver (hepatic) disease or seizures? Yes No
If yes, please describe: _____

9. Are you pregnant, or is there a chance you may be pregnant? N/A Yes No

TO BE COMPLETED BY TECHNOLOGIST/BAPTIST M&S PERSONNEL ONLY ON ALL CONTRAST EXAMS

Patient Fasting? Yes No

Contrast type injected: _____ Volume _____ ml. Lot#: _____ Exp. Date: _____

IV access: Time: _____ Location: _____ Catheter size/type: _____ Number of Attempts: _____

IV Started By: _____ Injected By: _____

Allergy problems post contrast? Yes No If yes, complete Contrast Incident Form. Date Lab Drawn: _____

Creatinine within normal limits Yes No NA If no, Creatinine level _____ GFR: _____

Comments: _____

I have reviewed this form with the patient

Reviewed By (Technologist Name): _____
Print name Signature Date

Reviewed By _____
Print name Signature Date

Name: _____

Date of Birth: _____ Acct/SS#: _____

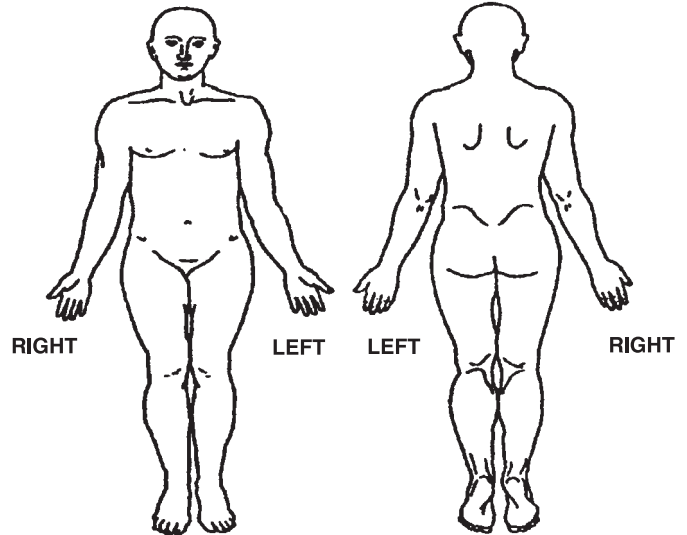


WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure (i.e., MRI, MR angiography, functional MRI, MR spectroscopy). **Do not enter** the MR system room or MR environment if you have any question or concern regarding an implant, device, or object. Consult the MRI Technologist or Radiologist **BEFORE** entering the MR system room. The MR system magnet is **ALWAYS** on.

Please indicate if you have any of the following:

- Yes No **Aneurysm clip(s)**
- Yes No **Cardiac pacemaker**
- Yes No Implanted cardioverter defibrillator (ICD)
- Yes No Electronic implant or device
- Yes No Magnetically-activated implant or device
- Yes No Neurostimulation system
- Yes No Spinal cord stimulator
- Yes No Internal electrodes or wires
- Yes No Bone growth/bone fusion stimulator
- Yes No Cochlear, otologic, or other ear implant
- Yes No GI Hemo-clips / GI capsules / GI camera
- Yes No Insulin or other infusion pump
- Yes No Implanted drug infusion device
- Yes No Any type of prosthesis (eye, penile, etc.)
- Yes No Heart valve prosthesis
- Yes No Eyelid spring or wire
- Yes No Artificial or prosthetic limb
- Yes No Metallic stent, filter, or coil
- Yes No Shunt (spinal or intraventricular)
- Yes No Vascular access port and/or catheter
- Yes No Radiation seeds or implants
- Yes No Swan-Ganz or thermodilution catheter
- Yes No Medication patch (Nicotine, Nitroglycerine)
- Yes No Wire mesh implant
- Yes No Tissue expander (e.g., breast)
- Yes No Surgical staples, clips, or metallic sutures
- Yes No Joint replacement (hip, knee, etc.)
- Yes No Bone/joint pin, screw, nail, wire, plate, etc.
- Yes No IUD, diaphragm. or pessary
- Yes No Dentures or partial plates
- Yes No Tattoo or permanent makeup
- Yes No Body piercing jewelry
- Yes No Hearing aid
(Remove before entering MR system room)
- Yes No Other implant _____
- Yes No Breathing problem or motion disorder
- Yes No Claustrophobia

Please mark on the figure(s) below the location of any implant or metal inside of or on your body.



! IMPORTANT INSTRUCTIONS

Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aids, dentures, partial plates, keys, beeper, cell phone, eyeglasses, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, credit cards, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal fasteners, & clothing with metallic threads.

Please consult the MRI Technologist or Radiologist if you have any question or concern BEFORE you enter the MR system room.

I attest that the above information is correct to the best of my knowledge. I have read and understand the contents of this form and had the opportunity to ask questions regarding the information on this form and the MR procedure that I am about to undergo.

Signature of Person Completing Form: _____ Date _____/_____/_____

Form Completed By: Patient Relative Other _____

I have reviewed this form with the patient

Reviewed By (Technologist Name): _____

Reviewed By _____