MRI Patient Screening Form - Part A

MRI SERVICES PATIENT INFORMATION

Patient Name: _____ Date of Exam: _____

Date of Birth: _____ Exam Ordered: _____

Medical Record #: _____ Diagnosis: _____

Patient Stated Weight: _____ Pt. Address: _____

Facility Name: _____ Patient's Zip Code: _____

Reason for Exam: _____

PATIENT HISTORY

MRI CANNOT be performed **if "Yes"** is answered to triple asterisked (***) questions.
Double asterisked (**) require a signed informed consent. Single asterisked (*) must be referred to radiologist for approval.

*** **Pacemaker or Pacemaker wires** (past or present)	❑ Yes	❑ No
*** **Small Bowel Endoscopy Capsule**	❑ Yes	❑ No
*** **Implanted Neurostimulators**	❑ Yes	❑ No
*** **Implanted Cardiac Defibrillator** (past or present)	❑ Yes	❑ No
*** **LVAD Device (Heart Pump)**	❑ Yes	❑ No
** **Pregnant / Breast Feeding**	❑ Yes	❑ No
* **Aneurysm Clips** (Verify and document safety or refer to the radiologist)	❑ Yes	❑ No
* **Carotid Clips**	❑ Yes	❑ No
* **Artificial Heart Valves**	❑ Yes	❑ No
* **Heart Stents**	❑ Yes	❑ No

If yes to previous two questions need -

Date: _____ Make: _____

Model: _____

* **History of severe hepatic disease/liver transplant/pending liver transplant** (no contrast for perioperative liver pts.)	❑ Yes	❑ No
* **Hypertension** (High Blood Pressure)	❑ Yes	❑ No
* **Vascular Clips/Grafts/Stents/Repair**	❑ Yes	❑ No
* **Surgical Clips**	❑ Yes	❑ No
* **Infusion Pump**	❑ Yes	❑ No
* **Programmable Shunt**	❑ Yes	❑ No
* **Allergies to IV dye, seafood, shellfish**	❑ Yes	❑ No
* **Dialysis/Renal Failure/Renal Insufficiency**	❑ Yes	❑ No
* **Iron deficiency or Anemia treated with Feraheme**	❑ Yes	❑ No
* **Metallic Foreign Body** (Gun shot wounds, metal shavings in eye, retinal buckle, etc.)	❑ Yes	❑ No
* **Prior Ear or Brain Surgery**	❑ Yes	❑ No
***Diabetes**	❑ Yes	❑ No
***Diabetic Pump**	❑ Yes	❑ No
***Wound Dressing (i.e. Acticoat 7)**	❑ Yes	❑ No
***Breast Tissue Expanders**	❑ Yes	❑ No

History of Falls	❑ Yes	❑ No
If yes, most recent fall date _____		
Asthma	❑ Yes	❑ No
Irregular Heartbeat	❑ Yes	❑ No
External Electrodes/Neurostimulators (Tens-unit)	❑ Yes	❑ No
Vena Cava Umbrella Filter	❑ Yes	❑ No
Endoscopy/Colonoscopy in past 2 years? (Possible GI Clips may require x-rays)	❑ Yes	❑ No
Latex Allergies	❑ Yes	❑ No
History of Cancer (Patient)	❑ Yes	❑ No
History of Breast Cancer	❑ Yes	❑ No
If yes, any lymph nodes removed?	❑ Yes	❑ No
Metallic Implant/Prosthesis/Orthopedic Devices	❑ Yes	❑ No
Removable Hearing Aid	❑ Yes	❑ No
Epilepsy (Seizures)	❑ Yes	❑ No
Uncooperative or Disoriented	❑ Yes	❑ No
Claustrophobia	❑ Yes	❑ No
Unable to Hold Still	❑ Yes	❑ No
Pins in Hair or Clothes	❑ Yes	❑ No
Hair Extensions/Hair Pieces/Wig	❑ Yes	❑ No
Braces	❑ Yes	❑ No
Removable Dental Work	❑ Yes	❑ No
Glitter/Permanent Eye Makeup	❑ Yes	❑ No
Tattoos and/or Body Piercing	❑ Yes	❑ No
Medication Skin Patches (Nitroglycerine, stop smoking, pain, birth control, etc.)	❑ Yes	❑ No

Colored contacts must be removed.

Please list previous surgeries : _____

_____

_____

Check Box below if a previous scan completed was similar to body part being examined today

Previous MRI ❑ Yes ❑ No Previous PET/PET/CT ❑ Yes ❑ No

Previous CT ❑ Yes ❑ No Previous X-Rays ❑ Yes ❑ No

If yes Specify Area

_____

_____

Any history with a * or ** must be approved by radiologist/supervising physician

Approved by: _____

Date: _____ **Time:** _____

Factors such as weight, body habitus and scan type may determine if scan can be performed.

Signature of Patient: _____ **Date:** _____
(Parent or Guardian if patient is a Minor or Incapacitated)

Interviewer's Signature: _____ **Date:** _____

I have reviewed this information with the patient or their legal guardian, power of attorney, next of kin, etc.

Tech's Signature: _____ **Date:** _____