IMAGING FACILITY
PRE-MRI SCREENING FORM

Date ____/____/____ MRI Number _____

Name _____ Height_____ Weight_____
Last name First name M.I.

Birth Date_____ Social Security No._____/_____/_____

Address_____ City_____

State_____ Zip Code_____ Phone (H)(_____)_____ (W)(_____)_____

Physician's name & address _____

_____

1. Have you ever had surgery or any similar invasive procedure? ❑ No ❑ Yes
   If yes, please list:
   Type:_____ Date:____/____/____
   Type:_____ Date:____/____/____

2. Have you had any previous studies? ❑ No ❑ Yes
   If yes, please list:.

	Body part	Date	Facility Location
MRI		/ /	
CT/CAT Scan		/ /	
X-Ray		/ /	
Ultrasound		/ /	
Nuclear Medicine		/ /	

3. Have you ever worked with metal (grinding, fabricating, etc.) or ever had an injury to the eye involving a metallic object (e.g., metallic slivers, shavings, foreign body)? ❑ No ❑ Yes
   If yes, please describe:_____

4. Are you pregnant or experiencing a late menstrual period? ❑ No ❑ Yes

5. Are you breast feeding? ❑ No ❑ Yes 6. Date of last menstrual period:____/____/____

7. Are you taking any type of fertility medication or having fertility treatments? ❑ No ❑ Yes

8. Are you taking oral contraceptives or receiving hormone treatment? ❑ No ❑ Yes

9. Are you currently taking or have you recently taken any medication? ❑ No ❑ Yes
   If yes, please list:_____

10. Do you have anemia or any diseases that affect your blood, a history of renal disease or seizures?
    ❑ No ❑ Yes
    If yes, please describe:_____

11. Do you have drug allergies? ❑ No ❑ Yes
    If yes, please list:_____

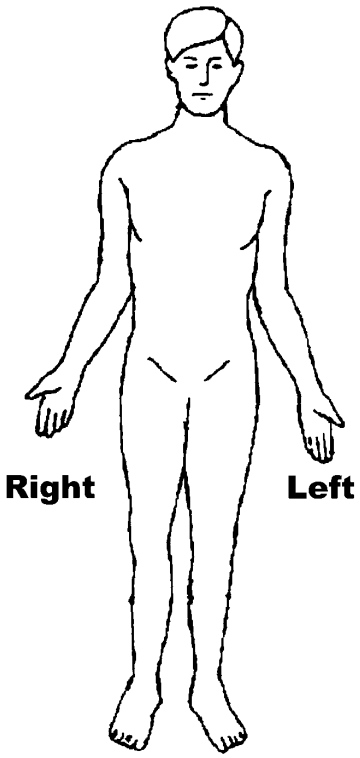
12. Have you ever had asthma, allergic reaction, respiratory disease, or other reaction to a contrast medium or dye used for an MRI or CT examination? ❑ No ❑ Yes
    If yes, please describe:_____

Some of the following items may be hazardous to your safety and some can interfere with the MRI examination. Please check the correct answer for each of the following. Do you have any of the following:

❑ Yes	❑ No	Cardiac pacemaker
❑ Yes	❑ No	Implanted cardiac defibrillator
❑ Yes	❑ No	Aneurysm clip(s)
❑ Yes	❑ No	Carotid artery vascular clamp
❑ Yes	❑ No	Neurostimulator
❑ Yes	❑ No	Insulin or infusion pump
❑ Yes	❑ No	Implanted drug infusion device
❑ Yes	❑ No	Bone growth/fusion stimulator
❑ Yes	❑ No	Cochlear, otologic, or ear implant
❑ Yes	❑ No	Any type of prosthesis (eye, penile, etc.)
❑ Yes	❑ No	Heart valve prosthesis
❑ Yes	❑ No	Artificial limb or joint
❑ Yes	❑ No	Electrodes (on body, head, or brain)
❑ Yes	❑ No	Intravascular stents, filters, or coils
❑ Yes	❑ No	Shunt (spinal or intraventricular)
❑ Yes	❑ No	Vascular access port and/or catheter
❑ Yes	❑ No	Swan-Ganz catheter
❑ Yes	❑ No	Any implant held in place by a magnet
❑ Yes	❑ No	Transdermal delivery system (Nitro)
❑ Yes	❑ No	IUD or diaphragm
❑ Yes	❑ No	Tattooed makeup (eyeliner, lips, etc.)
❑ Yes	❑ No	Body piercing(s)
❑ Yes	❑ No	Any metal fragments
❑ Yes	❑ No	Internal pacing wires
❑ Yes	❑ No	Aortic clip
❑ Yes	❑ No	Metal or wire mesh implants
❑ Yes	❑ No	Wire sutures or surgical staples
❑ Yes	❑ No	Harrington rods (spine)
❑ Yes	❑ No	Metal rods in bones
❑ Yes	❑ No	Joint replacement _____
❑ Yes	❑ No	Bone/joint pin, screw, nail, wire, plate
❑ Yes	❑ No	Hearing aid ***(Remove before MRI)***
❑ Yes	❑ No	Dentures ***(Remove before MRI)***
❑ Yes	❑ No	Breathing disorder
❑ Yes	❑ No	Motion disorder
❑ Yes	❑ No	Claustrophobia
❑ Yes	❑ No	Anxiety

Other, please explain:_____

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



Before your MRI, please remove all metallic objects including keys, hair pins, barrettes, jewelry, watch, safety pins, paperclips, money clip, credit cards, coins, pens, belt, metal buttons, pocket knife, & clothing with metal in the material.

NOTE: YOU ARE REQUIRED TO WEAR EARPLUGS OR EARPHONES DURING THE MRI EXAMINATION.

_____ Date____/____/____

Signature of Person Completing Form

Form completed by: ❑ Patient ❑ Relative:_____

Name & relationship to patient

❑ Physician or other:_____

Name & relationship to patient

To be completed by the MRI Facility Medical record number:_____ Completed by:_____

Procedure:_____ Diagnosis:_____

Clinical History:_____

_____

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