

# MRI Screening Form

**WARNING: MRI system is always on!** Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR. Do not enter the MR scan 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 exam room.

## Patient Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
 Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Body Part to be Examined: \_\_\_\_\_  
 Reason for MRI and/or Symptoms: \_\_\_\_\_  
 \_\_\_\_\_  
 How long have you had these symptoms? \_\_\_\_\_  
 Were you injured?  Yes  No If so, when? \_\_\_\_\_

## Medical Information

1. List prior surgeries \_\_\_\_\_  
\_\_\_\_\_
2. Have you had a prior imaging study or examination (MRI, CT, Ultrasound, X-ray, etc)?  Yes  No  
If yes, please list: (Exam, Body Part, Date, Facility): \_\_\_\_\_
3. Are you currently taking or have you recently taken any medication or drug?  Yes  No  
If yes, please describe: \_\_\_\_\_
4. Are you allergic to any medication?  Yes  No  
If yes, please describe: \_\_\_\_\_
5. Do you have a history of cancer?  Yes  No  
If yes, describe type: \_\_\_\_\_  
Describe current or past treatments: (i.e. radiation or chemotherapy) \_\_\_\_\_
6. Do you have a history of renal (kidney) disease or dialysis?  Yes  No
7. Do you have sickle cell anemia or sickle cell trait?  Yes  No
8. Are you a diabetic?  Yes  No

## Female Patients Only

1. Date of last menstrual period: \_\_\_\_\_ Post-menopausal?  Yes  No
2. Are you pregnant or experiencing a late menstrual period?  Yes  No
3. Hysterectomy  Yes  No If yes, give date: \_\_\_\_\_  
If yes, was it a **complete** hysterectomy? (removal of ovaries and uterus?) If yes, give date: \_\_\_\_\_
4. Are you currently breastfeeding?  Yes  No

Patient signature: \_\_\_\_\_

**Safety Information**

1. Have you had an injury to the eye involving a metallic object or fragment, (i.e. metallic slivers, shavings, foreign body, etc) Yes  No  
 If **yes**, has metal object been completely removed by a physician? Yes  No  
 If **yes**, were you told "it's all out"? Yes  No
2. Have you ever been injured by a metallic object or foreign body (i.e. BB, bullet, shrapnel, etc)? Yes  No
3. Do you have a history of asthma, allergic reaction, respiratory disease, or reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? Yes  No

If **yes** to any above safety questions, please describe: \_\_\_\_\_

**Please answer the following safety questions:**

- |   |   |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac Pacemaker                          | <input type="checkbox"/> Yes <input type="checkbox"/> No Claustrophobia                                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aneurysm clip(s)                           | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Seeds or Implants                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted cardioverter defibrillator (ICD) | <input type="checkbox"/> Yes <input type="checkbox"/> No Swan Ganz or thermodilution catheter           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Electronic implant or device               | <input type="checkbox"/> Yes <input type="checkbox"/> No Medication patch                               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Magnetically-activated implant or device   | <input type="checkbox"/> Yes <input type="checkbox"/> No Any metallic fragment or foreign body          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Neurostimulator system                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Wire mesh implant                              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Spinal cord stimulator                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Tissue expander (e.g. breast)                  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Internal electrodes or wires               | <input type="checkbox"/> Yes <input type="checkbox"/> No Surgical staples, clips or metallic sutures    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bone growth/bone fusion stimulator         | <input type="checkbox"/> Yes <input type="checkbox"/> No Joint replacement (hip, knee, etc.)            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cochlear, otologic, or other ear implant   | <input type="checkbox"/> Yes <input type="checkbox"/> No Bone/joint pin, screw, nail, wire, plate, etc. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Insulin or other infusion pump             | <input type="checkbox"/> Yes <input type="checkbox"/> No IUD, diaphragm, or pessary                     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Implanted drug infusion device             | <input type="checkbox"/> Yes <input type="checkbox"/> No Dentures or partial plates                     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Any type of prosthesis (eye, penile, etc.) | <input type="checkbox"/> Yes <input type="checkbox"/> No Tattoo or permanent makeup                     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart valve prosthesis                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Body piercing jewelry                          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Eyelid spring or wire                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Hearing Aid                                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial or prosthetic limb              | <input type="checkbox"/> Yes <input type="checkbox"/> No Other implant _____                            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Metallic stent, filter, or coil            | <input type="checkbox"/> Yes <input type="checkbox"/> No Seizure, motion disorder or breathing problem  |

**WARNING:** Before entering the MR environment or MR system room, you must remove the following: medication patches, hearing aids, dentures, partial plates, keys, cell phone, eyeglasses, hair pins, jewelry, body piercing jewelry, watch, safety pins, paperclips, money clip, bank cards, magnetic strip cards, coins, pens, pocket knife, nail clipper, tools, clothing with metal.

\*\*\*WARNING\*\*\* Medication patch causes burns to the skin if not removed.

Please list any additional information you feel is pertinent to today's exam: \_\_\_\_\_

\_\_\_\_\_  
 Patient signature

\_\_\_\_\_  
 Technologist signature

\_\_\_\_\_  
 Date

**STAFF USE ONLY**

Staff Safety Notes: \_\_\_\_\_

Staff Signature: \_\_\_\_\_

Discussion / Approval: \_\_\_\_\_

**Medical Records Release**

Please sign the medical release below.

This allows our facility to obtain your previous films or prior medical history as it pertains to today's exam.

Submitted to: \_\_\_\_\_  
 (Name of Facility)

Patient Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Type of records requested: \_\_\_\_\_

I hereby authorize and request you to release the complete medical records mentioned above, including copies of the reports in your possession, to Diagnostic Imaging Centers, P.A.

\_\_\_\_\_  
 (Patient or Authorized Person)

\_\_\_\_\_  
 Date