METRO MRI CENTER

MRI SAFETY SCREENING FORM FOR PATIENTS MRI #_____

Name_____ _____ _____ Today's Date_____
Last name First name Middle Initial

❒ Male ❒Female Age_____ Height_____ Weight_____

Address_____ Birth Date:_____

City_____ State_____ Zip_____ Social Security #:_____

Telephone (home) (_____) _____ Telephone (work) (_____) _____

Reason for MRI and/or Symptoms_____

1. Have you had prior surgery (operation, biopsies, etc.) of any kind? ❒ Yes ❒ No
   If yes, please list the date and type of surgery:
   Date_____ Surgery_____ Date_____ Surgery_____
   Date_____ Surgery_____ Date_____ Surgery_____
   Date_____ Surgery_____ Date_____ Surgery_____
   Date_____ Surgery_____ Date_____ Surgery_____
2. Have you had an endoscopy procedure (colonoscopy, upper GI, arthroscopy, etc)? ❒ Yes ❒ No Date_____
3. List previous MRI, CT, Ultrasound, X-rays or other tests related to the body part we are scanning today.

	Body Part	Date	Facility where test was performed
MRI	_____	_____	_____
CT/CAT Scan	_____	_____	_____
X-Ray	_____	_____	_____
Ultrasound	_____	_____	_____
Other_____	_____	_____	_____

4. Have you ever experienced any problem related to a previous MRI examination or procedure? ❒ Yes ❒ No
5. Have you had an injury to the eye involving a metallic object or fragment (metallic slivers, etc) ❒ Yes ❒ No
   If yes, did you receive medical attention for the eye injury? ❒ Yes ❒ No
6. Have you ever been injured by a metallic object or foreign body (bullet, BB, shrapnel, etc.)? ❒ Yes ❒ No
7. Are you currently taking or have you recently taken any medication or drug? ❒ Yes ❒ No
   If yes, please list:_____
8. Do you have any allergies? ❒ Yes ❒ No
   If yes, please list:_____
9. Do you have a history of asthma, allergic reaction, respiratory disease, or a reaction to a contrast medium or dye used for an MRI, CT, or X-ray examination? ❒ Yes ❒ No
10. Do you have: Renal (kidney) disease, kidney failure, kidney transplant, acute kidney injury (AKI) ? ❒ Yes ❒ No

High blood pressure (hypertension)	❒ Yes ❒ No	Diabetes	❒ Yes ❒ No
History of cancer	❒ Yes ❒ No	Seizure disorder	❒ Yes ❒ No
Anemia or other blood disease	❒ Yes ❒ No	Liver (hepatic) disease	❒ Yes ❒ No

For female patients:

11. Date of last menstrual period (mm/dd/yyyy): ____/ ____/ ____ Post menopausal? ❒ Yes ❒ No
12. Are you pregnant or experiencing a late menstrual period? ❒ Yes ❒ No
13. Are you taking oral contraceptives or receiving hormonal treatment or hormone replacement therapy? ❒ Yes ❒ No
14. Are you taking any type of fertility medication or having fertility treatments? ❒ Yes ❒ No
    If yes, please describe:_____
15. Are you currently breast feeding? ❒ Yes ❒ No

Gadolinium (contrast) Injection

Your MRI exam may include an injection of gadolinium-based MR contrast to help enhance certain structures in the body. Gadolinium is FDA approved. **You must inform the MR technologist if you have impaired or reduced kidney function.** On rare occasions, allergic-type reactions (hives/itching) and other adverse events have occurred. The safety of injecting gadolinium in children under two years old, pregnant women, and nursing mothers has not yet been determined. Our staff is available to answer questions you may have regarding the use of gadolinium.

Patient Name:_____ MR#_____

WARNING: Certain implants, devices, or objects may be hazardous to you and/or may interfere with the MR procedure. **Do Not Enter** the MRI 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. We **Strongly** recommend using ear plugs or headphones for your MRI exam since some patients may find the noise levels unacceptable.

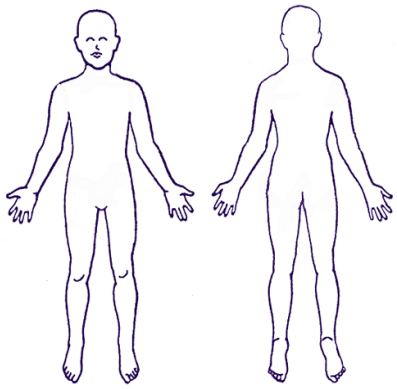
The MR System magnet is ALWAYS on.

Please check YES or NO to indicate if you have any of the following:

❒ Yes ❒ No Aneurysm repair or clip(s) ***Circle***: Brain Abdomen
❒ Yes ❒ No Cardiac Pacemaker or pacing wires
❒ 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, stapes or any ear implant
❒ Yes ❒ No Insulin or other infusion or IV pump
❒ Yes ❒ No Implanted drug infusion device
❒ Yes ❒ No Foley catheter with temperature sensor
❒ Yes ❒ No Any type of prosthesis (eye, penile implant, etc)
❒ Yes ❒ No Pill Cam Capsule (endoscopy device)
❒ Yes ❒ No Heart valve replacement or prosthesis
❒ Yes ❒ No Eyelid spring, wire, or eyelid weights
❒ Yes ❒ No Lens implant, IMT lens implant,, retinal tack
❒ Yes ❒ No Artificial limb (prosthesis) List:_____
❒ Yes ❒ No Stent, filter, or coil
❒ Yes ❒ No Shunt - spine or brain (intraventricular)
❒ Yes ❒ No Vascular access port or catheter (porta-cath)
❒ Yes ❒ No Radiation seeds or implants
❒ Yes ❒ No Swan-Ganz or thermodilution catheter
❒ Yes ❒ No Medication patch (nicotine, nitro, birth control)
❒ Yes ❒ No Any metal fragment or foreign body
❒ Yes ❒ No Wire mesh implant
❒ Yes ❒ No Tissue expander (ie., breast)
❒ Yes ❒ No Surgical staples, clips, or metallic sutures

❒ Yes ❒ No Joint replacement (hip, knee, etc.)
❒ Yes ❒ No Bone or joint pin, screw, nail, wire, plate, etc.
❒ Yes ❒ No IUD, diaphragm, or pessary
❒ Yes ❒ No Dentures, partial plates
❒ Yes ❒ No Magnetic dental implants
❒ Yes ❒ No Tattoos or permanent cosmetics
❒ Yes ❒ No Body piercing jewelry ***(Remove)***
❒ Yes ❒ No Body modification implants
❒ Yes ❒ No Hearing aid (***Remove)***
❒ Yes ❒ No Other implant_____
❒ Yes ❒ No Breathing problems or tremors
❒ Yes ❒ No Claustrophobia

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



IMPORTANT INSTRUCTIONS: Before entering the MR environment or MR system room, you must remove all metallic objects including hearing aid, keys, beeper, cell phone, hair pins, barrettes, jewelry, body piercing jewelry, watch, safety pins, paper clips, money clip, credit cards/magnetic strip cards, coins, pens, pocket knife, lighter, nail clipper, tools, dentures, clothing with metal or metallic threads. Please consult the MRI Technologist if you have any question or concern BEFORE you enter the MR scan 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 regarding the MR procedure I am about to undergo. I hereby give my consent for the MRI examination.

Signature **X**:_____ Date_____

Form Completed By: ☐ Patient ☐ Relative ☐ Nurse _____ _____
Print name Relationship to patient

For MR Technologist use only BP:_____ Taken by_____ Time:_____
Impaired renal function? ❒ No ❒ Yes If YES, Creatinine _____ GFR _____ Date:_____
Contrast used: _____ Drawn Up By:_____ Lot #_____Exp. Date:_____
Pt. Wt:_____ Dosage _____ml & _____ml Saline Flush ❒Power Injector ❒Hand Injection

Site	Needle	By	Comments	# of attempts:_____
_____	w/_____	_____	_____	
_____	w/_____	_____	_____	

Post Injection BP:_____ Taken by_____ Time:_____
Patient's Condition:_____ Physician on Standby:_____
List Any Reaction:_____